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Corporate Takeover of Teaching Hospitals


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ARTICLES

CORPORATE TAKEOVER OF TEACHING HOSPITALS

M. GREGG BLOCHE*

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This Article is dedicated to the memory of my father.

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I. INTRODUCTION

The Victorian-style structures of the McLean psychiatric hospital sprawl across more than two hundred acres of gentle, leafy hills, inviting a sense of immunity from intrusion. But on August 1, 1983, the economic forces that are radically reshaping American medicine intruded abruptly. As some of McLean's doctors learned from their car radios while escaping to Cape Cod vacation spots,¹ the huge Hospital Corporation of America (HCA), owner of more than three hundred for-profit hospitals, had made an offer to buy the Harvard-affiliated hospital. McLean was to retain its Harvard affiliation. However, if the deal were approved, it would become a for-profit subsidiary of HCA. Trustees of the Massachusetts General Hospital, McLean's corporate parent, viewed the offer favorably.

Many Harvard faculty, at McLean and elsewhere, were astonished and outraged.² In the ensuing weeks, leading faculty opponents publicly cast the proposed involvement with the for-profit sector as an intolerable compromise of traditional academic and clinical "values."³ Behind the scenes, a group of part-time clinical faculty organized a campaign to prevent the sale by putting legal and other pressure on the trustees. The group hired a law firm which discreetly approached the Massachusetts State Attorney General with the contention that McLean's 1811 charter forbade the transfer, which would accompany the sale, of certain property given to McLean in perpetuity.⁴ The Attorney General privately communicated to the trustees her willingness to go into court to block the sale—a rare use of her statutory authority to enforce charitable trusts.⁵ Amidst the vocal faculty opposition and the looming prospect of litigation, a committee of senior Harvard Medical School faculty named by the school's Dean recommended that the HCA offer be rejected.⁶ The

1. Telephone Interview with Francis deMarneffe, M.D., General Director of McLean Hospital (Nov. 1985).

2. Barbara J. Culliton, *University Hospitals for Sale*, 223 SCIENCE 909 (1984); Telephone Interviews, on condition of anonymity, with McLean officials (Nov. 1985) [hereinafter Anonymous Interviews].

3. Culliton, *supra* note 2.

4. Anonymous Interviews, *supra* note 2. These sources said they were not familiar with the legal details of the clinical faculty group's argument. I was unable to reach the group's leader for comment; nor was I able to learn the identity of the law firm.

5. *Id.*; see also *infra* text accompanying notes 449-462 (discussing the enforcement by state attorneys general of restrictions on charitable gifts).

6. Final Report of the Faculty Advisory Committee on McLean Hospital (Nov. 1, 1983) (unpublished report, on file in the Office of the Dean of the Harvard Medical School) [hereinafter Faculty Advisory Committee Report].

Massachusetts General Hospital trustees then announced they would not pursue the matter further.⁷

The deal with HCA was dead.⁸ Yet in urging rejection, the faculty panel had given the proposal a remarkably favorable review. In language curiously at odds with its negative verdict, the panel's report characterized the plan as an imaginative solution to McLean's long-term needs for stable income, capital, and administrative expertise.⁹

Managers at major teaching hospitals across the nation watched the confrontation in Boston with intense interest. Squeezed between stingier third-party reimbursement policies, mounting market pressures, and a new austerity in federal support, academic medical centers in the 1980s faced a frustrating struggle to meet growing capital and income needs.¹⁰ The new wealth of the several huge, investor-owned health care corporations that emerged from intensive merger and acquisition activity during the late 1970s and early 1980s¹¹ offered tempting possibilities.

7. Letter from Francis Burr, Chairman of the Board of Trustees, to Daniel Tosteson, M.D., Dean of the Harvard Medical School (Nov. 1, 1983) (on file at the Office of the Dean of the Harvard Medical School) [hereinafter Burr Letter]. According to one senior McLean official, fear of adverse publicity from litigation over the 1811 charter was decisive for the trustees and the faculty committee. Anonymous Interviews, *supra* note 2. But Burr, the trustees' Chairman, and Francis deMarneffe, M.D., McLean's General Director, insisted that the faculty opposition itself, not fear of a lawsuit by the Attorney General, was the primary factor. Telephone Interview with Francis Burr (June 1986); Telephone Interview with Francis deMarneffe, M.D., *supra* note 1.

8. The Faculty Advisory Committee also considered a long-term lease in lieu of a sale to HCA but rejected this option because it would still involve the operation of McLean on a for-profit basis. Faculty Advisory Committee Report, *supra* note 6, at 14.

9. *Id.* This language presaged a less adventuresome step—McLean's entry into a joint venture with another investor-owned hospital chain, American Medical International (AMI), shortly after the HCA deal's demise. McLean and AMI became partners in a new, not-for-profit firm that markets mental health services—e.g., substance abuse programs and contract management of psychiatric facilities—to employers and health care providers nationwide. The venture permitted McLean to maintain its not-for-profit status while tapping the financial and marketing resources of an investor-owned chain. The financial benefits for McLean were not nearly as great as those promised by the HCA deal, but the plan was more acceptable to McLean's constituencies. Judith Feder & Jack Hadley, *A Threat or a Promise: Acquisition of Teaching Hospitals by Investor-Owned Chains*, 12 J. HEALTH POL. POL'Y & L. 325, 338-39 (1987).

10. See, e.g., David E. Rogers & Robert J. Blendon, *The Academic Medical Center Today*, 100 ANNALS INTERNAL MED. 751 (1984).

11. See Bradford H. Gray, *Overview: Origins and Trends*, 61 BULL. N.Y. ACAD. MED. 7, 9-17 (1985) (Keynote Address to 1984 Annual Health Conference on *The New Entrepreneurialism in Health Care*, sponsored by the Committee on Medicine in Society of the New York Academy of Medicine). The industry's "big four" were the Hospital Corporation of America, Humana Inc., National Medical Enterprises Inc., and American Medical International Inc. By 1985, the four owned more than 750 hospitals in the United States, about eleven percent of the national total. Including the nearly 300 additional facilities under management contract, the chains controlled about fifteen percent of the nation's hospitals. They achieved their remarkable growth largely

Those who feared that by succumbing to this temptation, academic centers would sacrifice the ideals of service and scholarship to the profit motive were relieved by the McLean deal's collapse. "I was very proud of this university," said Arnold Relman, editor of the *New England Journal of Medicine* and a professor of medicine at Harvard.¹² But a year later, in November 1984, the first purchase of a university's primary teaching hospital by an investor-owned chain was finalized. American Medical International Inc. (AMI) paid \$99.3 million for Omaha, Nebraska's Saint Joseph Hospital, the main teaching facility for the Creighton University School of Medicine.¹³

A national association of Catholic hospitals threatened to expel Saint Joseph.¹⁴ Some members of the Association of American Medical Colleges' Council of Teaching Hospitals (COTH) urged that investor-owned institutions be barred from membership. Yet by mid-1985, investor-owned chains had become owners of three more academic medical centers.¹⁵ Another center had entered a long-term leasing agreement with a chain—Humana Inc.—and two medical schools had begun joint ventures with HCA to build and operate new teaching hospitals.¹⁶ Ten academic centers had signed management contracts with HCA,¹⁷ a step that for community hospitals has frequently preceded an outright purchase or leasing arrangement.

At meetings of academic medical leaders around the nation, rumors of impending deals circulated. Universities that owned teaching hospitals worried that fiscal troubles at these facilities could become a severe

through the acquisition of freestanding proprietary (for-profit) hospitals and smaller proprietary chains in the South and West.

12. Culliton, *supra* note 2, at 911.

13. Jean Evangelauf, *Many Universities Are Weighing Sale of Their Hospitals*, CHRON. HIGHER EDUC., Feb. 6, 1985, at 1, 20.

14. Linda Punch, *Catholic Providers Undaunted in Wake of Saint Joseph Sale*, MOD. HEALTHCARE, Nov. 15, 1984, at 69 (Angry officials of the Catholic Health Association (CHA), representing 628 hospitals and 282 long-term care facilities, warn that the Saint Joseph sale jeopardized its CHA membership.). CHA president John Curley Jr. declared that a hospital run "primarily for a profit motive is contrary to the basic values that have been a part of the Catholic healthcare tradition." *Id.*

15. They were (1) the Wesley Medical Center (affiliated with the University of Kansas School of Medicine; purchased by HCA); (2) the West Florida Hospital Regional Medical Center (affiliated with the University of Florida College of Medicine; purchased by HCA); and (3) the University of Southern California Hospital (affiliated with that university's School of Medicine; purchased by National Medical Enterprises, Inc.). Marsha F. Goldsmith, *Investor-Related Academic Health Center: "An Uncertain Courtship?"*, 253 JAMA 3049, 3051 (1985) (defining an "academic medical center" as "a teaching hospital with medical students and resident physicians, closely related to a school of medicine, where research programs are carried on").

16. *Id.*

17. *Id.*

drain on other academic programs.¹⁸ Religious orders and other independent, not-for-profit owners of university-linked hospitals wondered whether they could better perform their missions by selling financially risky hospital operations, and then using the proceeds to create foundations for the support of medical education and research, indigent care, and other health-related services.¹⁹ Managers of financially troubled academic centers that were engaged in talks with for-profit chains bristled at claims by Relman and others that they were flirting with a sell-out of fundamental values.²⁰

At least in the short run, the hopes and fears inspired by the investor-owned chains proved overblown. In the late 1980s, aggressive public and private sector medical cost containment efforts forced the chains into a retrenchment mode. The chains proved poorly prepared to cope with tighter restraints on Medicare's payments to hospitals, aggressive auditing of clinical care by private insurers, and declining inpatient utilization. The industry had anticipated these pressures and fashioned a strategic response. In the mid-1980s the three largest for-profit chains developed integrated health insurance and service plans in an effort to expand their shares of the hospital services market.²¹ However, this vertical integration strategy met fierce competition from established insurers, health maintenance organizations (HMOs), and other prepaid health plans. Heavy insurance losses, combined with declining hospital utilization rates and increasingly parsimonious reimbursement from third-party payers, forced firm managers to abandon their expansionary aspirations for the time being.²²

18. Evangelauf, *supra* note 13, at 20.

19. Montague Brown & Barbara McCool, *Boards Consider Several Factors in Trading Hospital for Foundation*, MOD. HEALTHCARE, Jan. 18, 1985, at 40; Mark Tatge, *More Not-for-Profits Mull Sellouts to Form 'New Breed' of Foundation*, MOD. HEALTHCARE, Jan. 18, 1985, at 40.

20. Defending his institution's willingness to consider selling its hospital to AMI, Ronald P. Kaufman, M.D., vice president for medical affairs at George Washington University, characterized the attitude of Relman and other critics as contempt by the "haves" for the struggles of the "have nots." "We were not surprised but somewhat disappointed when the editor of the New England Journal was quoted as stating 'I look askance at the alliance being proposed at George Washington University.' . . . For a profession like ours, steeped in the tradition of inquiry and the scientific method, to label any carefully constructed exploration as 'a bad idea' seems, at least to me, to be a contradiction of our basic philosophy of enlightened investigation." Kaufman, Remarks to the Council of Teaching Hospitals' Annual Meeting (May 18, 1984) (unpublished text on file in the office of the Vice President for Medical Affairs at George Washington University).

21. See *infra* text accompanying notes 192-227.

22. Judith Nemes, *For-Profit Chains Look Beyond the Bottom Line*, MOD. HEALTHCARE, Mar. 12, 1990, at 27.

The chains lost interest in buying or leasing additional academic centers,²³ and growing doubts about corporate balance sheets led some medical schools to withdraw from acquisition and leasing negotiations.²⁴ Between 1986 and 1990, the for-profit chains signed no new purchase or lease agreements involving academic centers. Instead, the chains focused on adapting to leaner times. Two of the three largest aborted their insurance ventures and sold off groups of struggling hospitals to employee ownership plans.²⁵ All tightened their management styles, eliminating unprofitable beds and developing cost-conscious utilization review programs. In 1989, the second and fourth largest chains went private, an indication that major new acquisitions were not part of their pared-down strategic plans.²⁶

The industry's retrenchment and restructuring efforts achieved a quick reversal of fortunes. By 1990, financial analysts were characterizing the chains' adjustments as an impressive success.²⁷ Four of the five largest chains reported hefty increases in profits in 1989.²⁸ The industry leader, Humana, Inc., which alone stood by its insurance venture despite heavy losses, turned the corner to insurance profitability in 1989.²⁹ The firm began a new round of hospital and HMO acquisitions with an eye toward marketing vertically integrated insurance and health services

23. Telephone Interview with Michael Bromberg, Executive Director of the Federation of American Health Systems (the investor-owned hospital chains' trade association) (Oct. 1990) [hereinafter Bromberg Interview]; see, e.g., Michael Abramowitz, *GWU Hospital Ends Leasing Talks*, WASH. POST, Oct. 17, 1986, at F1 (American Medical International's mounting financial problems and resulting retrenchment led it to break off negotiations with George Washington University over a long-term lease of GWU Hospital to AMI).

24. See, e.g., Howard Waitzkin et al., *Deciding Against Corporate Management of a State-Supported Academic Medical Center*, 315 NEW ENG. J. MED. 1299, 1302 (1986) (reporting that faculty concern about the financial prospects of American Medical International was critical in the University of California's decision not to sell the University of California at Irvine Medical Center to AMI).

25. Nemes, *supra* note 22, at 33-36. HCA was the nation's largest for-profit chain until it spun off 104 struggling acute-care hospitals to an Employee Stock Ownership Plan (ESOP), HealthTrust, in 1987 (making Humana, Inc. the largest, HCA the second largest, HealthTrust the third, and AMI the fourth). AMI, the third biggest before the creation of HealthTrust, sold 36 hospitals to an ESOP in 1988. *Id.*

26. *Id.* at 33, 36. Each executed leveraged buyouts, leaving them with high debt-to-equity ratios.

27. *Id.*

28. Jay Greene & Judith Nemes, *Survey: Multi-Unit Providers: Quality and Productivity Programs Pay Off for Leaner Systems*, MOD. HEALTHCARE, May 21, 1990, at 21. Only AMI, the fourth largest, reported 1989 losses.

29. Stephen Phillips, *Humana Regains that Healthy Glow*, BUS. WEEK, May 22, 1989, at 127 (reporting that the insurance division eked out its first operating profit during the quarter ending Feb. 28, 1989).

packages nationwide.³⁰ Other major chains planned selective acquisitions in the mental health, substance abuse, and rehabilitative medicine fields.³¹ A prominent Wall Street analyst predicted a new round of acquisitions of nonprofit hospitals, including teaching centers, in the 1990s,³² and an academic observer of the industry characterized the new decade as "an era of incredible opportunity" for the investor-owned chains.³³

Meanwhile, through the late 1980s the financial strain on America's teaching hospitals intensified. Employers, who were anxious about the effect of soaring medical costs on their ability to compete, put unprecedented pressure on hospitals to hold down expenses. Academic centers, which traditionally charged more than nonteaching hospitals in order to pay for education, research, and care for the uninsured, felt the squeeze most acutely. Under pressure from corporate clients, private insurers objected to hospital charges that included subsidies for academic activities.³⁴ Moreover, federal subsidies for teaching hospitals under the Medicare program were cut in the late 1980s as Congress and the President sought to control entitlement programs, which were perceived as responsible for soaring budget deficits. Payments to all hospitals for clinical services to the poor under the Medicaid program fell further behind rising costs, adding to the strain on teaching facilities with high proportions of indigent patients. Federal support for university-based biomedical research failed to keep pace with inflation. And as deficit-cutting negotiations between Congress and the President approached a climax in the fall of 1990, both sides considered unprecedented Medicare cuts that were likely to hit academic centers especially hard.

The financial future of American academic medicine today appears bleak. Growing market pressure from private payers and the prospect of long-term federal austerity endanger the health of all academic centers³⁵

30. Michael Stroud, *Humana's Rx: Hospitals + HMOs = Profits*, INVESTOR'S DAILY, Apr. 18, 1990, at 1 (describing Humana's plans to offer integrated health plans in at least six new metropolitan areas over the next five years).

31. Highlights of the Wall Street Transcript's Health Care Services Industry Roundtable (Mar. 8, 1989) (interview with Joyce Albers) [hereinafter Highlights of Roundtable].

32. *Id.*

33. Nemes, *supra* note 22, at 27 (quoting Robert Taylor, Director of Graduate Studies in Health Administration at Duke University). Expansionary thinking at the other major chains has thus far been more restrained. Bromberg Interview, *supra* note 23.

34. See *infra* text accompanying notes 114-20.

35. Even the most wealthy and prestigious academic centers today face growing pressures from cost-conscious payers, aggressive non-academic competitors, and federal and state budgetary austerity. See Glen Kramon, *Coaxing the Stanford Elephant to Dance: Squeezed From All Sides, a Giant Medical Center Learns to Cut Costs and Compete*, N.Y. TIMES, Nov. 11, 1990, § 3, at 1.

and the survival of some. Concerned that hospital ownership in this grim environment threatens endowments and the future of nonmedical programs, some universities are contemplating divestiture of their hospitals.³⁶ For medical schools and for the worried owners of their affiliated hospitals, the financial, marketing, and management strength of the for-profit health services sector is again attractive. In October, 1990, Humana announced plans for the first acquisition of a major teaching hospital by an investor-owned chain since 1986.³⁷ The extent to which teaching centers will seek out the resources of this vast and growing industry is uncertain. But in recent decades academic medical leaders have displayed a remarkable capacity to tap new funding sources as economic circumstances have changed.³⁸ Some health care industry observers predict that hard-pressed teaching hospitals will turn to the investor-owned sector in the 1990s.³⁹ Many of the leaders of American academic medicine, however, remain deeply skeptical about inviting for-profit firms into the academic setting.

This Article explores the potential and the dangers of this novel form of collaboration between academic medicine and the for-profit world. I focus on those arrangements—purchases and leasing agreements—by which investor-owned corporations operate, for a profit, hospitals that serve as major medical teaching and research sites.⁴⁰ I begin by reviewing how the evolving needs of academic medical centers and for-profit hospital chains have generated mutual interest in such arrangements. I then consider some frequently expressed ethical, economic, and other public policy objections to the provision of hospital services by for-profit firms. Opponents of the acquisition and leasing of teaching hospitals by for-profit entities have built their cases upon these objections. I

36. Julie Johnsson, *Politics, Power Struggles, a Part of Divestiture Battle for University Hospitals*, HOSPITALS, Feb. 20, 1990, at 46.

37. In the Fall of 1990, Humana announced an agreement to purchase the Michael Reese Hospital and its 240,000 member HMO. Milt Freudenheim, *Talking Deals: What Humana Likes in Chicago*, N.Y. TIMES, Oct. 4, 1990, at D2. Michael Reese is a major teaching facility for the University of Illinois School of Medicine. The purchase was completed in March, 1991, after Humana obtained the necessary regulatory approval. Judith Nemes, *Humana Completes Michael Reese Acquisition*, MODERN HEALTHCARE, Mar. 11, 1991, at 30.

38. See *infra* text accompanying notes 42-91.

39. See, e.g., Highlights of Roundtable, *supra* note 31 (predicting a new round of acquisitions of nonprofit hospitals, including teaching centers, by for-profit chains during the next five years).

40. Management contracts, by which nonprofit hospitals employ, for a fixed fee, investor-owned companies to provide administrative services will not be a principle focus of this paper. The experience of some academic centers with such contracts, however, will be drawn on in assessing the potential benefits and hazards of acquisition and leasing arrangements.

argue that on close inspection these objections fail and that the underlying concerns they express do not warrant opposition to the operation of teaching hospitals by investor-owned firms. Creative institutional design can enable parties to reap the benefits of such arrangements while protecting—even enhancing—academic centers' ability to perform their missions of teaching, research, and clinical service.

I also review in brief some potential legal obstacles to sale and leasing agreements and to full realization of their advantages. In contemplating such arrangements, academic managers and their for-profit counterparts must pay heed to myriad federal and state restrictions. I focus in particular on tax considerations and the dilemmas posed by limits on the use of charitable gifts. With a few possible exceptions, no legal problem poses an insurmountable barrier to the execution of a sale or lease agreement. Nevertheless, judicious institutional design, sensitive and well-planned approaches to regulatory authorities, and even litigation may be necessary in some cases to effect an arrangement and maximize its benefits.

I conclude with some recommendations about (1) the process by which an academic medical center should decide whether to enter sale or lease negotiations with a for-profit firm, and (2) the contract terms a medical school and other involved nonprofit parties should insist upon or at least press for in negotiations. The decision process, I argue, should be public and should involve representatives of an academic medical center's diverse constituencies at an early stage. A public process, open to input from many sources, will not only enhance the quality of decisions by increasing decision makers' knowledge of their constituencies' problems and preferences; it will also build understanding and support by imbuing participants in the process with a sense of shared dilemmas and accomplishment. Contractual language, I urge, should specify the for-profit firm's financial obligations and establish systems of joint governance designed to preserve academic authority over education and research. Contract terms should also provide for academic control (or at least veto power) over new corporate ventures involving the hospital. Finally, contracts should specify procedures for settling disputes between the owner or lessor and involved nonprofit parties, and should include buy-back or lease cancellation options.

II. BACKGROUND: THE DEVELOPING FINANCIAL SQUEEZE ON ACADEMIC MEDICAL CENTERS

The mounting woes of teaching hospitals cannot be seen apart from the economic and political forces that are radically altering the structure of medical care delivery. For thirty years after World War II, America's great academic medical centers expanded unceasingly, thriving on an astonishing rise in federal support and on generous third-party payment for clinical services. But over the next decade the attitudes and policies that had fueled this extraordinary expansion underwent basic changes that cast doubt on the dependability of federal and private third-party payer support for maintenance, let alone continued growth.

A. THE YEARS OF FEDERAL LARGESS

At the end of World War II, private, for-profit enterprises—the drug companies—were the dominant institutional actors in medical research. They spent an estimated \$40 million in 1945 on largely applied research at their own facilities.⁴¹ Private foundations, institutes, and a few elite universities funded other applied work and virtually all American basic biomedical research. In 1945, total support from these sources was an estimated \$25 million.⁴² In that year, the National Institute of Health (NIH), the chief research arm of the Federal Public Health Service, spent only \$180,000.⁴³ Students' tuition paid the cost of medical education, with occasional help from philanthropic sources. The typical clinical department was fortunate to have a single full-time faculty member; private practitioners did most of the teaching, in return for the prestige of a medical school affiliation.

Yet President Roosevelt's unprecedented wartime program of federally sponsored science suggested a new model for the support of civilian medical research. The Committee on Medical Research (CMR) of Roosevelt's Office of Scientific Research and Development spent \$15 million during the war years on a crash program that yielded lifesaving

41. RICHARD H. SHRYOCK, *AMERICAN MEDICAL RESEARCH* 135-36 (1947).

42. *Id.* Several additional sources provided a smaller amount of private support. These included professional societies (e.g., the American Medical Association), nonprofit groups interested in single diseases (e.g. the National Tuberculosis Association), group medical practices (e.g., the Mayo Clinic), and the Metropolitan Life Insurance Co. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 339 (1982).

43. STEPHEN R. STRICKLAND, *POLITICS, SCIENCE, AND DREAD DISEASE: A SHORT HISTORY OF UNITED STATES MEDICAL RESEARCH POLICY* 29 (1972).

advances against infectious disease and trauma.⁴⁴ The CMR program supported privately employed scientists at independent laboratories, and it featured minimal federal control once money was awarded.⁴⁵ The urgent necessities of combat overcame the medical establishment's fierce prewar resistance to federal financing of research,⁴⁶ and the scientific triumphs bought with CMR dollars motivated Congress to expand its support for medical research in peacetime.

1. NIH Grants and Covert Cross-Subsidization

At the war's end, CMR-sponsored work was placed under the aegis of the NIH. By 1947, NIH research spending had risen to \$4 million.⁴⁷ Catalyzed by a savvy lay lobby, a triangular alliance of cooperative agency officials, prominent scientists, and well-placed congressional allies won an astonishing series of annual NIH spending increases.⁴⁸ By 1950, the agency's budget had soared to \$46.3 million.⁴⁹ To the consternation

44. These included the first method for the mass production of penicillin, the isolation of gamma globulin and other therapeutically useful derivatives from whole blood, and (after Japanese military advances had cut off the supply of quinine) the synthesis of an antimalarial agent, atabrine, more efficacious than quinine. Between the two World Wars the U.S. Army's incidence of deaths from disease dropped from 14.1 to 0.6 per 1000 soldiers. STARR, *supra* note 42, at 336, 340-41.

45. *Id.* at 341.

46. See, e.g., Editorial, *The American Foundation Proposals for Medical Care*, 109 JAMA 1280 (1937) (The American Medical Association demanded "prompt disclaimers" from "the unthinking physicians" who endorsed a proposal for public financing of medical research, education, and care for the indigent.).

47. STRICKLAND, *supra* note 43, at 29.

48. The lobbying efforts of Mary Lasker, a wealthy and well-connected pioneer in the adaptation of mass-marketing techniques to private fundraising for medical research, played the key role in forging this classic Washington, D.C. power triangle. With Florence Mahoney, whose influential husband owned the Cox chain of newspapers, Lasker artfully cultivated key members of congressional appropriations committees, reminding them of the public's admiration for medical research. Working closely with a cadre of prominent physician-scientists skilled in public relations (cynics dubbed them "Mary and her little lambs"), she coaxed reluctant academics to "think big" when asked to advise appropriations committees. See RUFUS E. MILES, JR., *THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE* (1974); STRICKLAND, *supra* note 43, at 32-54.

NIH officials tacitly played along. Each year the agency's senior administrators prepared budget proposals that then moved upward through the Executive Branch bureaucracy. Typically, the Secretary of the Department of Health, Education, and Welfare (DHEW) made initial cuts; the Bureau of the Budget then imposed more. Congressional appropriations panels proclaimed their indignation and invited NIH officials to tell them how much more might fruitfully be spent. Agency administrators cooperated in the ritual, providing testimony which became the basis for hefty congressional increases. NATALIE D. SPINGARN, *HEARTBEAT: THE POLITICS OF HEALTH RESEARCH* 27-28 (1976). The agency's "budget-busting" behavior infuriated DHEW and budget bureau officials. But the politically sacrosanct status of health research enabled NIH to serve its growing constituency of researchers and lay backers without retaliation from successive Democratic and Republican Administrations.

49. STARR, *supra* note 42, at 343.

of many scientists, this potent alliance exploited lay concern with particular diseases, pressing successfully for the creation of research institutes organized by disease category instead of scientific discipline. Some charged that the burgeoning research program was being shaped more by political opportunism than by scientific opportunity,⁵⁰ but the flood of federal dollars submerged such considerations. Writers of NIH grant proposals learned to couch their ideas in language that accented potential clinical results. The NIH budget rose to \$81 million by 1955 and to \$400 million by 1960.⁵¹ Federal dollars poured outward from NIH institutes to the nation's academic medical centers, fueling an unprecedented expansion.

Direct federal support for medical education was blocked in the 1950s by the American Medical Association (AMA).⁵² But generous NIH grants, ostensibly limited to the support of research and research training, paid the salaries of new faculty who taught medical students, trained residents, and cared for patients. NIH money was also channeled to support medical school graduates—clinical fellows—who did some research while in training for lucrative clinical specialties. Academic administrators rationalized this cross-subsidization by arguing that one could not become a competent clinical investigator without also seeing patients and doing some teaching.⁵³ Such cross-subsidization, as Arnold Relman admitted, “was not intended by Congress, nor was it often admitted in public, but deans and department chairmen knew what they were doing [I]f you wanted to build a department, it was the NIH or nothing.”⁵⁴ Thus NIH dollars, managed cleverly by academic entrepreneurs, supported the rapid evolution of academic medical centers into “sprawling, complex organizations.” Between 1950 and 1960, total full-time faculty positions almost tripled nationwide, from 4,212 to 11,319.⁵⁵ By fiscal year 1965-1966, fifty-three percent of all medical school revenue

50. Complaints about the politicization of the NIH research agenda by “disease of the month club” pleaders have been a recurrent theme. SPINGARN, *supra* note 48, at 69-91 (discussing tension between lay focus on particular diseases and researchers’ belief that resources are most efficiently used when directed toward fields with the greatest “scientific opportunity”).

51. STARR, *supra* note 42, at 347 (citing CONGRESSIONAL QUARTERLY SERVICE, CONGRESS AND THE NATION, 1945-64: A REVIEW OF GOVERNMENT AND POLITICS IN THE POSTWAR YEARS 1132 (1965)).

52. STRICKLAND, *supra* note 43, at 55-74 (describing the AMA lobby’s successful opposition to initiatives in Congress aimed at increasing the number of medical school places via direct “capitation” grants to medical schools and scholarships for students).

53. Arnold S. Relman, *Who Will Pay for Medical Education in Our Teaching Hospitals?*, 226 SCIENCE 20 (1984).

54. *Id.*

55. STARR, *supra* note 42, at 352.

came from the federal government, largely through research grants and contracts.⁵⁶ At some teaching centers, moreover, this support was supplemented during the 1950s and 1960s by direct federal subsidies for hospital construction.⁵⁷

2. Medicare and Medicaid

Congressional passage in 1965 of the Medicare and Medicaid insurance programs for the elderly, disabled, and indigent opened another large-bore infusion line of federal dollars to academic medical centers. In an effort to accommodate the hospital industry, legislators and the Johnson administration agreed to a system of Medicare payment for inpatient services based on each hospital's costs. Rules for calculating costs allowed hospitals to charge, at an accelerated rate, for depreciation on their capital assets, including those paid for with philanthropic contributions and federal construction subsidies. Thus, the Medicare billing mechanism offered hospitals an unrestricted new source of capital.⁵⁸ Moreover, Medicare permitted hospitals to name "fiscal intermediaries"—usually private insurance carriers—to administer and audit billings. Thus, billing and auditing were performed by private entities that sympathized with hospital interests and lacked any incentive to seriously scrutinize hospitals' claimed costs.

Similarly, Medicare reimbursement for doctors' services was administered by private insurers, appointed by the Department of Health, Education and Welfare (DHEW), who lacked any incentive to monitor and control costs.⁵⁹ Medicare's vague payment standard—reimbursement for "customary" and "prevailing" or "reasonable" fees—invited physicians to push fees upward to new "customary" levels. When some did so, the administering insurers went along.⁶⁰ Under this vague standard, highly technical procedures became especially lucrative. Fees were set

56. Relman, *supra* note 53, at 20.

57. Under the Hospital Survey and Construction (Hill-Burton) Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040, the federal government disbursed \$3.7 billion between 1947 and 1971 to support construction of health care facilities. More than three-fourths of this money went to hospitals (including some teaching centers), allocated according to a formula based on state populations and per capita income. STARR, *supra* note 42, at 348-50. Hill-Burton was phased out in the early 1970s. *Id.*

58. *Id.* at 375. Reimbursement for depreciation made the capital subsidy largest for the newest, most costly facilities, thereby creating an incentive for construction out of proportion to market-determined need for hospital beds. *Id.*

59. *Id.* DHEW generally appointed regional Blue Shield plans, doctor-sponsored systems established a few decades earlier to protect physicians from lay-controlled insurers and pre-payment plans. *Id.* at 306-10.

60. *Id.* at 385.

for many procedures at their moment of introduction, while they were relatively complicated and time-consuming for attending physicians. Although practitioners typically simplified new procedures over time and delegated routine technical details to low-paid house staff and paraprofessionals, they maintained or even raised the "customary" attending physician fees.⁶¹

Federal aid to the states for care of the indigent under Medicaid was accompanied by stringent eligibility criteria that left many poor people in a purgatory between Medicaid and private or Medicare coverage.⁶² But Medicaid dollars were a windfall for hospitals burdened by bad debt from indigent care.

B. PERMISSIVE THIRD-PARTY PAYMENT AND CREATIVE CLINICAL ENTREPRENEURSHIP

1. *Rapid Growth and Mounting Dependency*

Academic medical centers moved quickly to tap the vast potential of the new federal programs and to take advantage of a parallel rise in private coverage offered by employers. Entrepreneurial academic administrators and clinicians set up faculty practice plans that won new cadres of patients and a new pool of potential hospital admissions. Operating in an environment free from meaningful cost control, academic centers set prices for outpatient and hospital care high enough to provide large cross-subsidies for clinical research, education, and—in many cases—inefficient bureaucracy. Usually, these prices were much greater than those of non-academic competitors. As Relman acknowledges, the federal government and private insurers

had not explicitly agreed to support education and research in the teaching hospitals. . . . [W]e privately justified our higher hospital charges by the quality of the tertiary care given . . . and by our conviction that the teaching hospitals were an essential national resource . . . , [but] we never argued this publicly and therefore never had the explicit agreement of the payers or the public.⁶³

The new clinical entrepreneurship met with spectacular success just as growth in NIH allocations began to slow. Between 1965 and 1982, total patient care income at American medical schools jumped from \$49

61. *Id.* at 386 (citing coronary bypass surgery as a glaring example).

62. *Id.* at 374.

63. Relman, *supra* note 53, at 21.

million to \$2.14 billion,⁶⁴ a forty-four-fold increase. This represented a rise from 5.6 percent of all medical school income to thirty percent. Meanwhile, the percentage of total income derived from federal programs (largely research grants and contracts) other than Medicare and Medicaid dropped from fifty-three to twenty-eight.⁶⁵ Medical schools assembled large faculties in the clinical specialties⁶⁶—especially those specialties that performed lucrative technical procedures and were responsible for high volumes of hospital admissions. These faculty members were expected to generate the income necessary to support their own salaries, benefits, and clinical research programs.⁶⁷ Academic centers responded to their environment's economic incentives as any frankly profit-seeking enterprise might, and grew explosively.⁶⁸ As they expanded, they became more and more vitally dependent on a continuation of the federal and private third-party payer largess that had powered their remarkable growth.

The extraordinary national commitment to medical care rested on Americans' rarely challenged faith that technological medicine was the surest means of pursuing health. Through the 1950s a series of advances in highly effective, relatively low-cost technologies, especially drug therapies and vaccination,⁶⁹ lent support to this faith. Well into the next decade, health policy debate focused almost exclusively on questions of

64. *Id.* (citing figures (not adjusted for inflation) supplied by the Association of American Medical Colleges).

65. *Id.* This drop masks a more-than-four-fold rise in this category of federal support, from \$465 million to \$2.0 billion (calculated from the cited figures).

66. Between 1960 and 1977, the number of full-time medical school faculty in the United States rose nearly four-fold, to 44,762. Most of this rise occurred in the clinical specialties. LU ANN ADAY ET AL., *HEALTH CARE IN THE UNITED STATES: EQUITABLE FOR WHOM?* (1980).

67. Leighton E. Cluff, *Economic Incentives of Faculty Practice: Are They Distorting the Medical School's Mission?*, 250 JAMA 2931 (1983).

68. For example, in the 1960s leaders in the emerging field of community medicine urged the creation of neighborhood centers to provide comprehensive, prevention-oriented ambulatory health care and education in low-income areas. During the late 1960s Congress allocated funds to DHEW and the Office of Economic Opportunity (OEO) for the development of demonstration centers. Faculty at many medical schools helped to organize and staff these centers, which often went beyond the bounds of reactive, treatment-oriented medical care. In the early 1970s, when federal dollars for the centers dried up, the medical schools' commitment to the centers cooled. In the face of evidence that the centers' preventive and educational efforts improved community health and cut hospital use, KAREN DAVIS & CATHY SCHOEN, *HEALTH AND THE WAR ON POVERTY* 173-200 (1978), academic medical centers put their indigent care efforts into more traditional services, such as hospital-based outpatient clinics and high-technology inpatient care, which was paid for by Medicaid. See STARR, *supra* note 42, at 370-72.

69. See VICTOR R. FUCHS, *WHO SHALL LIVE? HEALTH, ECONOMICS, AND SOCIAL CHOICE* 16 (1974).

access and distribution of medical care;⁷⁰ its value was presumed. In the late 1960s, however, this consensus began to unravel.

2. *The Rise of Cost-Consciousness*

Within a few years of the start-up of Medicare and Medicaid, a new medical care cost explosion captured public attention. Per capita medical costs, up thirty-nine percent from 1960 to 1965, rose seventy percent during the next five years, with hospital costs leading the way. Between 1965 and 1970, federal and state health expenditures almost tripled, jumping from \$10.8 billion to \$27.8 billion.⁷¹ Economists and others debated the relative significance of several factors—liberal third-party payment (mostly by the federal government⁷²), technological advances, and higher wages won by restive labor unions representing hospital support staff. By 1970 total medical care expenditures had risen to 7.3 percent of the gross national product, up from 4.5 percent in 1950,⁷³ and politicians and the press spoke of a health care “crisis.”⁷⁴

The rhetoric of “crisis” invited newly intense scrutiny into whether medical care dollars were buying health. Under close examination medical practice fared poorly. A series of studies by economists and health service researchers suggested that wide differences in physicians’ use of surgery, drugs, and hospitalization for many ailments had little impact upon health outcomes.⁷⁵ The use of many costly diagnostic and therapeutic modalities correlated more closely with the availability of third-party payment and technology-oriented specialists.⁷⁶ Differences in morbidity between subpopulations in the United States seemed more closely linked to environmental, genetic, and behavioral factors than to medical care.⁷⁷

70. STARR, *supra* note 42, at 335-78.

71. *See id.* at 384 (reporting that per capita expenditures rose from \$142 in 1960 to \$198 in 1965, then to \$336 in 1970).

72. FUCHS, *supra* note 69, at 81.

73. STARR, *supra* note 42, at 335.

74. *Id.* at 381.

75. *See* FUCHS, *supra* note 69, at 56-60.

76. Economist Martin Feldstein estimated in 1971 that each additional specialist induced \$39,000 more in hospital expenditures per year, without proven health benefit, than would an additional general practitioner. Martin S. Feldstein, *Hospital Cost Inflation: A Study of Nonprofit Price Dynamics*, 61 AM. ECON. REV. 853, 871 (1971).

77. FUCHS, *supra* note 69, at 6. For example, interstate variations in infant mortality rates did not correlate significantly with the number of physicians per capita after differences in income, schooling, and other environmental variables were accounted for. *Id.* at 36-37 (citing VICTOR R. FUCHS & MARCIA J. KRAMER, DETERMINANTS OF EXPENDITURES FOR PHYSICIANS’ SERVICES IN THE UNITED STATES, 1948-68 (1972)). In contrast, infant mortality correlated strongly with race

The evidence supported many health economists' developing belief that the medical care cost explosion was a demand-side phenomenon—the product of (1) an open-ended third-party payment system and (2) the willingness of physicians—as patients' purchasing agents⁷⁸—to spend insurers' dollars without regard for whether the spending contributed demonstrably to patients' well-being.⁷⁹ Martin Feldstein and others noted that the hospital industry, though largely nonprofit in form, reacted like a group of classic, income-maximizing firms, increasing price and supply in response to greater demand.⁸⁰

3. *Regulatory Failure and the Preservation of Cross-Subsidies*

Concern about escalating costs and uncertain benefits kept cost control near the top of the national health policy agenda through the 1970s. Though most economic analyses identified demand as the engine driving the system, a series of state and federal regulatory initiatives primarily attempted to control price and supply. Many state legislatures enacted rate regulation and certificate-of-need programs that required hospitals to obtain the approval of state administrative agencies before raising charges or making major capital investments.⁸¹ From August 1971 through April 1974 the Nixon administration's wage-price controls held medical inflation to an annual rate below that for the rest of the service

(the black rate was almost twice the white rate), schooling, and income (though above a threshold income level, thought to assure adequate nutrition, shelter, and sanitation, there seemed to be no further decline in mortality). *Id.* at 34-36.

78. The peculiar role of physicians in the health care economy has both demand and supply side aspects. As patients' purchasing agents, doctors create demand, yet they also supply some of the services they "purchase." Their incentives as suppliers—e.g., fees, gratification from patients' trust and reliance, and learned ideals of good "workmanship," FUCHS, *supra* note 69, at 60—may influence their decisions as purchasing agents. Herein may lie a source of the controversy over whether medical inflation is driven by demand or supply. While demand-oriented explanations focus on the doctor's role as a purchasing agent with broad discretion, *id.* at 57-60, supply-oriented theories tend to conceive of the clinician as provider of technically indicated services (rather rigidly determined by scientific principles of practice) in response to patients' needs.

79. Some physicians bristle at this interpretation, perceiving in it a charge of self-aggrandizement at the patient's expense. This interpretation, of course, need not imply anything so nasty. The classic Hippocratic ethic of undivided commitment to the individual patient prescribes, when third party payment protects the patient from the costs of *his individual* care, a clinical policy of doing all that might conceivably help, without regard for the scarcity of social resources.

80. See, e.g., Feldstein, *supra* note 76, at 853-54 (concluding that "despite the nonprofit nature of the hospital industry, hospital cost inflation can be explained by a model of dynamic price adjustment to excess demand," and explaining the components of inflation—e.g., higher wages and more costly technology—as consequences of the increased demand generated by insurance and technology-oriented specialists).

81. STARR, *supra* note 42, at 398-99.

economy.⁸² In 1972 Congress allowed DHEW, when calculating cost-based reimbursement rates for hospitals and nursing homes under Medicare, to ignore capital investments not approved by state planning agencies.⁸³ In the same legislation, Congress empowered DHEW to contract with panels of physicians—termed “Professional Standard Review Organizations” (PSROs)—which were to screen inpatient clinical records with an eye to denying Medicare reimbursement for unneeded services.⁸⁴ The most ambitious federal regulatory initiative—the National Health Planning and Resource Development Act of 1974—called for a nationwide web of state and federal planning agencies that were to limit and coordinate capital spending by health care institutions.⁸⁵

Perhaps regulation could have worked had legislation been crafted with sufficient force and clarity to actually restrain supply and price. But the reform initiatives of the 1970s were adulterated products, undermined by the many compromises necessary to placate entrenched interests.⁸⁶ Facing physician resistance, Congress limited PSRO review of Medicare billing to inpatient care and barred consumers and non-M.D. health professionals from becoming PSRO reviewers.⁸⁷ Under pressure from hospitals as well as doctors, the Congress that enacted the National Health Planning and Resource Development Act of 1974 did not empower the Act’s planning agencies to set rates, shut down existing care

82. *Id.* at 399, 406. Health services inflation averaged 4.9 percent during this period, compared with 5.2 percent for all other services. But after controls were lifted, the medical inflation rate rebounded to its more characteristic three point margin over the rates for other services and for the overall economy. *Id.* at 406.

83. 42 U.S.C. § 1320a-1 (1988).

84. 42 U.S.C. § 1395y(g) (1988).

85. Pub. L. No. 93-641, 88 Stat. 2225, *repealed by* Pub. L. No. 99-660, 100 Stat. 3799 (1987). The Act required states to enact certificate-of-need legislation and to establish “Health Planning and Development Agencies” and “Statewide Health Coordinating Councils.” It also created within DHEW a new “Bureau of Health Planning and Development” and a “National Health Planning Advisory Council.” A network of two hundred regional “Health Systems Agencies (HSAs), federally funded and directed by boards composed mostly of consumers, was to review all proposed capital spending by institutions and to develop three-year “Health System Plans.” The HSAs, which themselves lacked authority to block capital expenditures, were to submit their recommendations to state and federal planning agencies. *See STARR, supra* note 42, at 401-02.

86. *See* Robert R. Alford, *The Political Economy of Health Care: Dynamics Without Change*, 2 POL. & SOC’Y 127 (1982) (arguing that health care institutions are so “enormously resistant to change” that reform proposals cannot succeed politically without compromise that “successfully shields the funding, powers, and resources of the producing institutions from any basic structural change”).

87. Earlier versions had called for consumer and non-M.D. professional membership on review teams as well as inclusion of outpatient care within the scope of review. *STARR, supra* note 42, at 399-400.

facilities deemed unnecessary, or effectively control new capital spending.⁸⁸ DHEW's development of proposed PSRO review regulations, which took two years, spawned a reprise round of paralytic litigation.⁸⁹ Meanwhile, as Medicare and other permissive insurance schemes fed the system, medical expenditures more than tripled in the 1970s, climbing to 9.4 percent of the GNP by 1980.⁹⁰

Thus, despite a series of regulatory initiatives, academic medical centers were able in the 1970s to continue setting prices high enough to provide large cross-subsidies for research and education. As the NIH budget leveled off, teaching centers became increasingly dependent on vast clinical care enterprises to support academic activities.

C. THE MARKET REACTS: FROM ABUNDANCE TO CRISIS

In the 1980s, however, economic forces unleashed by the medical system's unrestrained growth increasingly endangered this support. The new threat developed along several lines, on both the supply and demand sides of the medical economy.

1. *New Tertiary Care Competitors*

First, by permitting the proliferation of subspecialty training programs during the 1960s and 1970s, the academic centers gradually undermined their own role as clinical meccas—regional referral centers for patients with particularly complex or severe problems. Graduates of these subspecialty programs diffused into surrounding communities. They easily persuaded community hospital boards to invest in the technology necessary to provide lucrative tertiary care services. Increasingly, community hospitals and their developing networks of highly skilled subspecialists became the great academic centers' competitors.⁹¹

2. *Private Action to Contain Costs*

Meanwhile, on the demand side, an aroused private sector emerged in the 1980s as a potent countervailing power to the suppliers of medical care. Through the regulatory battles of the 1970s the large employers, labor unions, and insurers that paid the bills remained relatively passive

88. *See id.* at 401-02.

89. *Id.* at 406-07.

90. OFFICE OF RESEARCH STATISTICS & TECHNOLOGY, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, HEALTH: UNITED STATES, 263 (1981).

91. Leighton E. Cluff, *Medical Schools, Clinical Faculty, and Community Physicians*, 247 JAMA 200 (1982).

while providers wielded their clout to thwart government control. But as medical costs escalated unremittingly and American businesses faced mounting competitive pressures, corporate cost cutters became newly attentive to their health care bills.⁹² Giant employers, sometimes working in concert with union leaders, began to use their economic power to negotiate less permissive arrangements with medical care providers.⁹³ Insurers scrutinized cost- and charge-based reimbursement claims more closely, aware that automatic pass-through of costs to health plan buyers undermined the competitiveness of insurance plans. In short, America's large private purchasers of medical care began to impose their restraining will upon the doctor-patient alliance that had once been the exclusive arbiter of demand.

3. *Prepaid Health Plans and Prospective Hospital Reimbursement*

A new entrepreneurship in health care responded creatively to the emerging private sector demand for spending restraint. Insurance companies, health maintenance organizations (HMOs), groups of physicians, and consortiums of hospitals developed myriad financing schemes that had in common the concept of a prepaid annual allocation for comprehensive clinical services.⁹⁴ These prepaid plans⁹⁵ vied with each other for contracts with large employers, offering bulk discounts in an effort to fill

92. See, e.g., Harry B. Wolfe et al., *Health Care Cost Containment: Challenge to Industry* (1980) (unpublished monograph prepared by the management consulting firm of Arthur D. Little, urging executives to redesign employee benefits packages, develop self-insurance and prepaid health services plans, upgrade information systems, and exercise their influence with hospital boards and government regulatory bodies).

93. See N.R. Kleinfield, *When the Boss Becomes Your Doctor*, N.Y. TIMES, Jan. 5, 1986, § 3 (Business), at 1 (reporting on attempts by many companies to trim their health insurance costs by imposing stricter requirements for reimbursement, often at the expense of physician and patient autonomy).

94. In the early 1970s an unlikely coalition of preventive medicine activists and conservatives concerned with cost control argued that federal policy should encourage the private development of comprehensive, prepaid health care systems. Proponents of such systems reminded policy-makers that the financial incentives of fee-for-service care penalized health preservation and cost-effective therapy. See, e.g., Paul M. Ellwood et al., *Health Maintenance Strategy*, 9 MED. CARE 291 (1971). In 1973, with Nixon administration support, Congress enacted a scheme of federal subsidies for the start-up of prepaid programs, which became known as Health Maintenance Organizations (HMOs). However, the scheme included strict minimum benefit and enrollment requirements, and the unenthusiastic response disappointed HMO advocates. Although studies showed that HMOs cut costs substantially by dramatically reducing hospitalization, only four percent of Americans had enrolled in HMOs by 1979. STARR, *supra* note 42, at 407-08, 415.

In the late 1970s, however, Congress passed a series of amendments that increased subsidies and cut qualifying requirements. *Id.* at 415. HMO entrepreneurship increased dramatically. By 1985 national HMO enrollment approached ten percent. Robert Blendon, *The Major Forces Affecting the Academic Health Centers in the 1990s*, in THE INVESTOR-RELATED ACADEMIC HEALTH CENTER

excess service capacity. By assuming the risk of inpatient expenses, the prepaid schemes gave themselves ample incentive to reduce hospital utilization. Meanwhile, insurers restructured conventional cost- and charge-based insurance plans to shift some of the risk of inpatient expenses to subscribers.⁹⁶

In 1983 the nation's largest insurer, Medicare, pioneered a system of payment to hospitals based on diagnostic categories rather than services rendered. Under the new system, each hospitalized Medicare patient is assigned to a "Diagnosis Related Group (DRG)" based on clinical diagnosis, major procedures performed, complications, and age.⁹⁷ Regardless of the costs actually incurred, the admitting hospital receives a lump sum

AND MEDICAL EDUCATION: AN UNCERTAIN COURTSHIP 17, 21 (1986) (proceedings of a 1985 conference jointly sponsored by the American Hospital Association, the American Medical Association, and the Association of American Medical Colleges).

95. Prepaid plans vary widely in their organizational design. At one extreme are HMOs, which provide a full range of outpatient and inpatient services under one corporate rubric and are thus able to impose cost-minimizing decision rules regarding hospitalization and the use of diagnostic and therapeutic procedures. HMO physicians, as employees, have relatively little freedom to make clinical decisions contrary to these rules.

At the other end of the spectrum is the Preferred Provider Organization (PPO). Under the PPO model, subscribers make annual prepayments into an insurance pool and in return are entitled to a defined set of services from participating physicians (the "preferred providers") in private practice. Participating physicians agree to accept discounted fees and to cooperate with the insurer's utilization review and managed care programs. In return, physicians gain access to a reliable stream of patients. Some PPO schemes also include hospital services. The insurance pool pays participating physicians on a fee-for-service basis. Because the physicians are independent practitioners, not employees, the insurer has less authority over their clinical decisions than would an HMO.

However, unlike traditional fee-for-service practice with third-party payment, under which an outside insurer bears the risk (or "moral hazard"), some forms of the PPO model put participating physicians collectively at risk by restricting their aggregate reimbursement (for services to subscribers) to the amount available in the common pool. The higher the aggregate use of services, the lower the pool's reimbursement rates for individual services. These reimbursement adjustments can be administered in various ways—e.g., by withholding a portion of physicians' anticipated fees until the end of each fiscal year, then making adjustments based on utilization for the year. The PPO can thereby *internalize*, albeit collectively, the moral hazard of insurance. A participating clinician, in his or her role as the patient's purchasing agent, could in theory "cheat" at colleagues' expense by using services more liberally than they do. But group discipline—and the ultimate sanction of expulsion from the PPO, with consequent loss of this portion of the offender's practice—renders "cheating" unlikely so long as non-subscriber demand is insufficient to replace the physician's subscriber practice.

96. See Blendon, *supra* note 94, at 22 (reporting a recent rise from thirty to sixty-three percent in the proportion of large employers that require their health insurance packages to include hospital deductibles). In contrast to the prepaid comprehensive care model, which targets physician incentives as the key to cost control, this approach aims to give patients sufficient incentive to become active and critical counterweights to their doctors' judgment.

97. See YALE UNIVERSITY SCHOOL OF ORGANIZATION AND MANAGEMENT, HEALTH SYSTEMS MANAGEMENT GROUP, THE NEW ICD-9-CM DIAGNOSIS RELATED GROUPS CLASSIFICATION SCHEME (1981).

payment based on the reimbursement rate for the patient's assigned DRG. Hospital management thus has a powerful incentive to minimize length of stay and use of costly ancillary services such as laboratory tests. Some private insurers are following the federal government's lead in developing DRG-based hospital reimbursement schemes.⁹⁸

Initially, the new Medicare system generated a handsome subsidy for academic centers' research, teaching, and other clinical activities, thanks to adjustments awarded by Congress to teaching hospitals.⁹⁹ During the first year of the new system, the nation's teaching centers enjoyed a twenty-three percent profit margin on their Medicare business.¹⁰⁰ But Medicare's DRG payment rates failed to keep pace with hospital cost inflation in the 1980s.¹⁰¹ By the end of the decade, teaching centers' overall Medicare profit margin had dropped to twelve percent.¹⁰² In 1990, the Bush Administration proposed a further, drastic reduction in this twelve percent subsidy. Noting that the nation's nonteaching hospitals enjoyed a Medicare profit margin of only one percent, the administration's senior health official declared that the subsidy was "far in excess" of what Medicare ought to provide.¹⁰³ An eleventh-hour budget compromise drafted by congressional Democrats and accepted by the

98. Interview with Edward Neuscler, Deputy Director of the Department of Policy Development and Research at the Health Insurance Association of America (Feb. 1992).

99. In enacting legislation setting up the DRG-based reimbursement system, Congress granted teaching hospitals an 11.59% across-the-board bonus plus additional adjustments based on each hospital's number of interns and residents. Cynthia Wallace, *Many Teaching Hospitals Fare Well Under Prospective Payment . . . For Now*, MOD. HEALTHCARE, Aug. 1, 1984, at 34, 38. With these adjustments, major teaching centers realized Medicare revenues twenty-three percent greater than Medicare-allowed costs during the first year of prospective payment. After the first three years, teaching hospitals continued to realize more than double the average profit margin of non-teaching hospitals from Medicare patients. Carl J. Schramm & Jon Gabel, *Prospective Payment: Some Retrospective Observations*, 318 NEW ENG. J. MED. 1681 (1988).

100. *Id.*

101. From fiscal year 1984 through fiscal year 1988, DRG rates rose by less than half of the sixteen percent increase in the "hospital market basket" cost during that period. Carol M. McCarthy, *DRGs—Five Years Later*, 318 NEW ENG. J. MED. 1683, 1684 (1988).

102. Press Briefing by Louis W. Sullivan, Secretary of the U.S. Dept. of Health and Human Services (Jan. 29, 1990) (transcript on file with Federal Information Systems Corp.).

103. *Id.* (proposing a one billion dollar reduction in Medicare payments to teaching hospitals). The administration's proposal for legislation to reduce the subsidy came as the Health Care Financing Administration (HCFA) proposed new reimbursement regulations for teaching hospitals, pursuant to section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1985), that would reduce their Medicare reimbursement by \$400 to \$600 million annually and limit future increases in Medicare's payment adjustment for teaching centers to rises in the Consumer Price Index. Patrick K. O'Hare, *Medicare GME Regulations: A Challenge for Teaching Hospitals*, HEALTHCARE FIN. MGMT., Feb. 1990, at 68.

President in October, 1990 left the subsidy largely intact.¹⁰⁴ However, in view of mounting pressure on Congress and the President to reduce domestic entitlement spending, its future is hardly secure.¹⁰⁵

4. *Physician Payment Reform*

The newest threat to clinical income is the federal government's bid to reduce payments to specialized physicians for technology-intensive services. In 1989, Congress enacted legislation instructing the Health Care Financing Administration (HCFA) to develop a Medicare fee schedule for physicians' services.¹⁰⁶ The new law eliminated the vague "customary" and "prevailing" or "reasonable" fee standard that had allowed physicians free rein to charge high fees for technology-oriented services.¹⁰⁷ In its place, Congress instructed HCFA to construct a fee schedule that would substantially reduce the disparity between Medicare's payments for technology-intensive procedures and for physicians' "cognitive" time (history taking, counseling, treatment planning, and so forth).¹⁰⁸

The schedule, to be phased in from 1992 to 1996, will be based on a relative value scale for physician services developed for HCFA in the 1980s via a multistage process of consultations and negotiations between doctors representing each clinical specialty.¹⁰⁹ Private third-party payers

104. Aside from a reduction in "disproportionate share" payments made to hospitals with heavy uncompensated care burdens in accordance with section 9105 of COBRA 1986, the final budget package for fiscal year 1991 left Medicare's adjustments for teaching hospitals unscathed. Interview with James Bentley, Vice President for Clinical Services, Association of American Medical Colleges (Nov. 1990).

105. The subsidy is especially vulnerable because it is funded through the Medicare program's regressive tax—a 1.45 percent levy on incomes up to \$130,200 per year, [1992 Index] Stand. Fed. Tax Rep. (CCH) ¶ 114—rather than through general tax revenues. In view of the tax fairness issue's growing political appeal, future congressional protection for the subsidy seems less likely.

106. Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), Pub. L. No. 101-239 tit. IX, 103 Stat. 2106.

107. See *supra* text accompanying notes 59-61.

108. John K. Iglehart, *The New Law on Medicare's Payments to Physicians*, 322 NEW ENG. J. MED. 1247 (1990).

109. The process was administered by researchers at the Harvard University School of Public Health, under contract from HCFA. The researchers enlisted the cooperation of the American Medical Association and the nation's medical specialty societies in a collective effort to develop a scale of valuations based on participants' conclusions about the time, technical skill, effort, judgment, and stress involved in providing particular clinical services. William C. Hsiao et al., *Results and Policy Implications of the Resource-Based Relative Value Study*, 319 NEW ENG. J. MED. 881 (1988). As currently envisioned, the relative value scale will reduce Medicare payments to some specialists—such as radiologists and chest surgeons—by up to twenty percent while raising payments to primary care physicians—such as family practitioners and internists—by up to thirty-seven percent. Iglehart, *Payments to Physicians*, *supra* note 108, at 1247.

are expected to follow Medicare's lead in adopting fee schedules that reduce payments for technology-intensive services.¹¹⁰ The fee schedule legislation was designed to be neutral in its overall impact upon Medicare spending for physician services.¹¹¹ But the fee schedule is likely to reduce the income-generating ability of academic physicians because they are disproportionately concentrated in highly specialized, technology-intensive specialties.¹¹²

5. *The Resulting Financial Crisis*

Within academic medical centers, these changes are inspiring a growing sense of crisis. Competition from community hospitals and new, entrepreneurial health plans, along with less permissive third-party payment and the countervailing power of corporate buyers of medical care, increasingly threaten the profitability of academic centers' patient care. Declining utilization and downward pressure on rates endanger the cross-subsidies from hospital services and faculty practice upon which the centers now rely to support training,¹¹³ clinical research, and indigent care.¹¹⁴ Academic leaders today face mounting current-account and

110. Spencer Rich, *Radical Change Ordered in Medicare Doctor Fees*, WASH. POST, Nov. 16, 1991, at A1; Martin Tolchin, *Changes Urged in Payments to Doctors*, N.Y. TIMES, Sept. 29, 1988, § A, at 18.

111. Iglehart, *supra* note 108, at 1248.

112. Marybeth Burke, *Hospitals Anticipate Pitfalls of Physician Payment Reform*, HOSPITALS, Feb. 20, 1990, at 38.

113. Academic medical leaders commonly assert that the training of interns and residents is a major contributor to teaching hospitals' higher costs—and to their need for cross-subsidies from the care of insured patients. *See, e.g.*, Relman, *supra* note 53. Those who benefit from today's medical care, academic physicians argue, ought to support the maintenance of the human capital base that makes possible the continuing provision of medical services. But it is hardly clear that interns and residents, or even medical students serving on hospital wards, are responsible for higher costs. Interns and residents do their clinical learning while working extraordinary hours—up to one hundred or more per week—at very low pay (often much lower, on an hourly basis, than that of nurses and other paraprofessionals). For a wide range of routine services, they are cheap substitutes for allied health professionals. They also perform many tasks that would otherwise require more attending physician time.

This latter benefit accrues in part to hospitals, which are able to spend fewer salaried attending physician hours on clinical care, and in part to private attendings, who are able to see more patients, perform more procedures, and achieve higher billing totals than they could without the helping hands of house staff physicians. A major teaching hospital once unsuccessfully tried to "tax" its affiliated private attendings for this benefit. RAYMOND S. DUFF & AUGUST B. HOLLINGSHEAD, *SICKNESS AND SOCIETY* 58 (1968). The proliferation of house staff programs in community hospitals during the last few decades suggests that interns and residents may actually be cost-savers. *What Are Teaching Hospitals' Costs?*, MOD. HEALTHCARE, Aug. 1, 1984, at 34.

114. In 1982, according to the American Association of Medical Colleges, teaching hospitals provided 47.2 percent of all free care while accounting for only 5.6 percent of the nation's acute care beds. Cynthia Wallace, *supra* note 99, at 34, 38.

capital-acquisition difficulties as they seek to maintain the vast enterprises their predecessors created with once-plentiful dollars from NIH and third-party payers.

No beneficent source of funds looms on the horizon as an alternative. A renewed surge in federal support, via either NIH or some other mechanism, is exceedingly unlikely given the current mood of alarm over unprecedented deficit spending.¹¹⁵ Perhaps for good reason,¹¹⁶ academic medicine today lacks the public support and political clout necessary to win a vast new federal commitment to high-cost, high-technology clinical methods.¹¹⁷ Private philanthropy, once a principal source of support for clinical care and research, now covers barely two percent of American medical costs and is unlikely to reverse its decline in relative significance.¹¹⁸ And for budget-minded corporate and third-party payers, the social benefits of medical teaching, research, and care for the indigent are externalities for which they have little incentive to pay.¹¹⁹ Academic centers, in short, must fend for themselves.

115. Blendon, *supra* note 94, at 27.

116. Disillusion with the promise of new technology has some empirical basis. *See, e.g.,* John Bailar & Elaine Smith, *Progress Against Cancer?*, 314 NEW ENG. J. MED. 1226 (1986) (epidemiological study concluding that massive investment in high-technology cancer therapies has failed to reduce cancer mortality and morbidity).

117. *See* Rogers & Blendon, *supra* note 10, at 751, 752 (noting the public perception of academic centers as villains responsible for training expensive subspecialist physicians increasingly fascinated by technology and more concerned with high income than with human needs).

Political implausibility, though, has not prevented a proliferation of proposals for a federal bailout. *See, e.g.,* P. Douglas & C. Thomas Smith, *Financing Graduate Medical Education in a Competitive Atmosphere: A Proposal to Create a Fund Underwriting This Vital Aspect of Health Care*, HOSPITALS, May 16, 1984, at 93 (proposing a vast new federal fund for the support of all residency training, to be allocated among institutions and specialties by panels of medical professors, in the manner of NIH peer review). To the extent that interns and residents actually save money and time for hospitals and attending physicians by providing cheap labor, *see supra* note 113, this plan would amount to a federal subsidy for physicians' incomes and teaching hospital expenses unrelated to residency training. Moreover, it would grant a single, intensely interested group broad power to make political judgments about the nation's needs for different kinds of clinical training. This "fox guarding the chicken coop" factor is hardly likely to endear the proposal to legislators aware of public doubts about the selflessness of highly paid subspecialists.

118. Blendon, *supra* note 94, at 27, 28. Between 1968 and 1981, the proportion of hospital construction dollars derived from private philanthropy dropped from twenty-four to four percent. Jo Ellen Mistarz, *Capital: A Crisis?*, 58 HOSPITALS 79 (1984) (citing AMERICAN HOSPITAL ASS'N, 1984 SURVEY OF SOURCES OF FUNDING FOR HOSPITAL CONSTRUCTION).

119. Former Johns Hopkins Hospital President Robert Heyssel, M.D. warns that corporate managers "are voting increasingly with their companies' dollars" against paying academic centers for anything beyond patient care services. "They are looking for the best price for employee health benefits," says Heyssel, and if that is inimical to academic medical centers, "so be it" as they see things. Donald E.L. Johnson, *Teaching Hospitals Seek New Funds, New Roles in Education*, MOD. HEALTHCARE, Dec. 1984, at 81.

III. ACADEMIC CENTERS' SEARCH FOR SOLUTIONS: THE ATTRactions OF SELLING OR LEASING OF HOSPITAL OPERATIONS

In this competitive and uncertain environment, academic medical managers are becoming reluctant entrepreneurs. To the chagrin of some,¹²⁰ academic medical managers are increasingly thinking like business executives, weighing clinical services in terms of their economic viability and fashioning innovative institutional arrangements.¹²¹ The hospital management literature of the last several years is replete with articles urging nonprofit hospital administrators to adopt income-maximizing capital investment¹²² and pricing¹²³ policies. Teaching hospitals

120. See, e.g., Robert Cunningham, *Entrepreneurialism In Medicine*, 309 NEW ENG. J. MED. 1313 (1983) (arguing that "entrepreneurial values" and "bottom-line consciousness" threaten "the personal care quality of the hospital environment"); Rashi Fein, *What Is Wrong with the Language of Medicine?*, 306 NEW ENG. J. MED. 863 (1982) ("The attitudes and methodology of economics" and cost-benefit analysis undermine patient trust and confidence.); David Hilfiker, *A Doctor's View of Modern Medicine*, N.Y. TIMES, Feb. 23, 1986, Magazine, at 44 (scathingly criticizing nonprofit hospitals, academic and otherwise, that consider patients' insurance status when making admissions decisions).

121. Miles Shore & Harry Levinson, *On Business and Medicine*, 313 NEW ENG. J. MED. 319 (1985). Shore and Levinson dismiss the notion that the new business consciousness threatens the clinical endeavor's "quality of caring." This view, they argue, is rooted in a "misunderstanding of the characteristics of successful business organizations." They draw upon the literature on the importance of corporate values and identity in building the public confidence necessary for business success. See TERRENCE DEAL & ALLEN KENNEDY, *CORPORATE CULTURES* (1984); THOMAS PETERS & ROBERT WATERMAN, JR., *IN SEARCH OF EXCELLENCE* (1982). In the new era of economic competition between medical care providers, Shore and Levinson assert, the ultimate winners will be those that preserve an "identity as caring institutions," not those willing to sacrifice this identity for short-term profits and expediency.

Cf. Arthur, *Delivering Care: Profit or Service?*, MED. NEWS & INT'L REP., Apr. 14, 1986, at 1, 11 (quoting warnings from health care marketing consultants that hospitals which promote new services strictly for short-term gain—e.g., filling empty beds—without regard for demonstrable community needs will eventually lose the confidence of patients and third-party payers).

122. See, e.g., Douglas A. Conrad, *Returns on Equity to Not-For-Profit Hospitals: Theory and Implementation*, 19 HEALTH SERVICES RES. 41 (1984). Conrad makes a theoretical argument which casts fundamental doubt on the distinction between nonprofit and for-profit hospitals in an era when capital expenditures are financed largely through debt, and philanthropic contributions to capital budgets are becoming vanishingly small. He notes that only creditors have an explicit claim to a nonprofit hospital's income, and that property rights to residual income after creditors are paid are ill-defined. Such income is typically plowed back into new capital investments or distributed in the form of programs, perquisites, or other benefits to managers and employees, trustees, staff physicians, and the community. But as nonprofit hospital capitalization approaches one hundred percent debt, the problem of ill-defined property rights to net income diminishes to the vanishing point. For the purpose of figuring management's fiduciary responsibility, creditors (increasingly at risk as the proportion of debt rises) effectively become equity-holders, obliging management to maximize income—and undermining the distinction between the for-profit and nonprofit forms.

are entering into a variety of multi-institutional arrangements¹²⁴ to negotiate for bulk purchasing discounts and to share managerial expertise. Academic administrators are huddling with attorneys and management consultants to plan profit-making subsidiary ventures in a range of closely and remotely related businesses.¹²⁵ Administrators, sometimes in concert with medical staffs,¹²⁶ are developing vertically integrated entities incorporating HMOs, ambulatory surgical centers, and other outpatient services.

The selling or leasing of hospital operations to investor-owned health care chains represents the most dramatic expression of this trend. A long-term lease or outright sale, followed by partnership between medical school and for-profit corporation, offers academic institutions a unique array of advantages. These advantages fall into four classes: insulation from risk to other academic programs; new support for hospital operations; new support for teaching and research; and expanded academic program opportunities.¹²⁷

123. *E.g.*, Daniel Sullivan, *Profit Maximization and Hospital-Based Outpatient Services*, J. AMBULATORY CARE MGMT., Feb. 1983, at 16 (urging income-maximizing strategy for setting inpatient and outpatient prices, taking into account varying price elasticities of demand for different services and different third-party payment schemes); *cf.* Irwin David, *Why Tax-Exempt Hospitals Need Profit*, HEALTHCARE FIN. MGMT., Sept. 1982, at 46 (arguing, based on computer simulations, that hospitals need profit for asset replacement in an inflationary environment).

124. Linda Punch, *Consortium Makes Effort to Surmount Difficulties, Aid University Hospitals*, MOD. HEALTHCARE, Dec. 1984, at 84 (reporting on activities of the University Hospital Consortium, a group of twenty-three university-owned teaching hospitals formed in 1984 to coordinate purchasing, joint venture development, and some management functions); *see also* Ronald Werft, *Multi-Institutional Arrangements: Multihospital Arrangements Hold Promise for Teaching Hospitals*, HOSPITALS, July 16, 1982, at 87; Donald Wegmiller, *Financing Strategies for Nonprofit Hospital Systems*, HEALTH AFF., Summer, 1983, at 48 (urging increased management, marketing, purchasing, and financial coordination among facilities).

125. Leland R. Kaiser, *Survival Strategies for Not-for-Profit Hospitals*, HOSP. PROGRESS, Dec. 1983, at 40, 42. The ventures range from such hospital-linked services as laundry and data processing to the rental of office space and even the development of shopping centers, restaurants, and bars.

126. *See, e.g., id.* at 40 (describing subsidiary corporations formed jointly by hospitals and medical staffs to co-venture new health services products, averting competition between hospital and physician-owned enterprises).

127. The discussion in this section considers the benefits of sale and leasing arrangements from the perspective of academic medical institutions. To the extent that the benefits to academic programs translate into net gains for society as a whole, the analytic vantage point adopted herein approaches an overall social welfare perspective. Potential differences between the social welfare perspective and the vantage point of academic medical centers arise from (1) the possibility that for-profit hospitals have pernicious effects that do not affect academic programs but that ought to count negatively in the social welfare calculus, and (2) the possibility that some academic programs aided by for-profit operation of teaching hospitals—for example, technology-oriented tertiary care activities—impose social costs in excess of their clinical and other benefits. The first possibility is considered *infra* Part V. The second possibility, an important concern in view of academic medicine's tendency to emphasize costly, high-technology therapies over inexpensive (and possibly more cost-

A. INSULATION FROM RISK TO OTHER ACADEMIC PROGRAMS

Increasingly concerned about the potential for huge operating losses and the difficulty of raising even maintenance capital, owners of teaching hospitals are tempted by the ultimate option—divestiture. Universities that own hospitals could be forced into devastating expenditures of endowment principal or cutbacks in other academic programs should their hospitals run big operating deficits. To insulate themselves from potential liability, several universities have already reconstituted their teaching hospitals as independent, nonprofit corporations.¹²⁸ Religious and fraternal orders that own hospitals face a similar risk to their other programs. Moreover, the overwhelming challenge of raising the capital needed to maintain a modern, tertiary care hospital threatens to divert attention from other development needs. Hospital ownership thus poses a mounting threat to other valued activities. Sale or leasing to a for-profit chain is one way to opt out of this danger.

B. NEW SUPPORT FOR HOSPITAL OPERATIONS

The human resources, market power, and financial strength of the investor-owned chains have the potential to improve substantially a teaching hospital's competitive posture in the medical marketplace. This translates into a greater likelihood that the hospital's medical school partner will be able to maintain or enhance the quality of its clinical teaching and research. Financial and marketing expertise, strategic planning and management skills, and economies of scale are among the advantages most often touted.¹²⁹ Observers generally believe that the leading for-profit chains tend to attract and retain superior management personnel.¹³⁰ Comparative studies of investor-owned and nonprofit community hospitals, matched for demographic factors and the clinical complexity of patients' illnesses, suggest that the for-profits' pricing strategies

effective) primary care and health promotion activities, merits consideration, but it lies beyond the scope of this Article.

128. Blendon, *supra* note 94, at 39 (citing the Universities of North Carolina, West Virginia, and Maryland); Julie Johnsson, *Politics, Power Struggles a Part of Divestiture Battle for University Hospitals*, HOSPITALS, Feb. 20, 1990, at 46.

129. See, e.g., Richard H. Egdahl, *Arrangements Under Investor-Owned Partnerships: Some Guidelines for Teaching Hospitals*, in THE INVESTOR-RELATED ACADEMIC HEALTH CENTER AND MEDICAL EDUCATION: AN UNCERTAIN COURTSHIP 41, 44-45 (1986); John G. Larson, *Factors in the Success of the Investor-Owned Hospitals: Implications for the Not-For-Profits*, HOSP. & HEALTH SERVICES ADMIN., March/April 1983, at 43.

130. Richard Siegrist, *Wall Street and the For-Profit Hospital Management Companies*, in THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT 35, 43-44 (Bradford H. Gray ed., 1983) (Most Wall Street analysts specializing in the health care

and collection programs are more effective at maximizing reimbursement from cost- and charge-based payers.¹³¹

The verdict is not yet in, however, on whether the for-profits' management skills give them a similar edge in controlling costs under prospective payment and prepaid health service plans. Industry observers say the centralized management style of the largest investor-owned firm—Humana—played a critical role in that company's successful development of vertically integrated, prepaid health plans. Aggressive oversight of physicians' treatment decisions sufficiently contained hospital costs to make Humana's prepaid plans profitable by the end of the 1980s.¹³² But Humana's principal competitors were less aggressive in

industry are highly impressed with the investor-owned chains' quality of management.). Industry observers interviewed during the preparation of this Article generally expressed the belief that investor-owned chains attract harder-working, more able managers than do most nonprofit hospitals.

On the other hand, Stanley Bergen, Jr., President of the University of Medicine and Dentistry of New Jersey, painted a sharply different picture. In 1983, Bergen's institution, which is state-owned, signed a hospital management contract with HCA. The deal's main appeal, Bergen said, was that it enabled the university to evade a state cap on administrative salaries which had made the hiring of qualified managers exceedingly difficult. For political reasons, according to Bergen, the state was "willing to hide [higher] salaries within the management contract, but not to pay greater salaries openly. If we had our choice, we probably would have hired our own." The university paid HCA a \$600,000 yearly fee, and the corporation brought in several managers at salaries well above the state cap.

Their performance, Bergen said, was disappointing. Insensitivity to academic needs was not a problem. Poor management was. Bergen cited indecisiveness, failure to reorganize billing procedures in preparation for DRG-based Medicare reimbursement, and poor handling of relations with community and minority constituencies. Several million dollars in savings promised by HCA before the contract was signed failed to materialize. HCA's corporate headquarters, Bergen charged, "did not keep an eye on this job the way they should have." Bergen said that while the for-profit chains may once have had an edge over the nonprofits in hiring high-quality managers, they are having difficulties now. "There are not a lot of top people out there." The chains' salaries have become less competitive compared with those in other private sector management fields, and the increased stress of health care management in today's austere environment is making the field less attractive to new entrants in both the for-profit and nonprofit sectors. Interview with Stanley Bergen, Jr., in Newark, N.J. (Jan. 1986).

131. See, e.g., LEWIN & ASSOCIATES, INC., *STUDIES IN THE COMPARATIVE PERFORMANCE OF INVESTOR-OWNED AND NOT-FOR-PROFIT HOSPITALS* (1981) (revealing a pattern of generally higher charges by investor-owned hospitals for ancillary services such as laboratory tests); Robert Pattison & Hallie Katz, *Investor-Owned and Not-For-Profit Hospitals: A Comparison Based on California Data*, 309 NEW ENG. J. MED. 347 (1983).

132. Interview with Michael Bromberg, Executive Director of the Federation of American Health Systems (Oct. 1990).

monitoring physician decision making and thus less successful in controlling costs during the 1980s.¹³³ Humana's success suggests that the centralized management capability of an investor-owned chain is a potentially powerful cost-control tool. But to the extent that firm managers achieve cost control by constraining clinicians' discretion, academic physicians are likely to resist "successful" management practices.

Nor has it been conclusively demonstrated that the investor-owned chains achieve unique economies of scale in the purchase or use of facilities and equipment.¹³⁴ However, there is evidence that the chains employ personnel more efficiently than do free-standing nonprofit and for-profit hospitals.¹³⁵ Moreover, the chains' sheer size is likely to give the chains greater fiscal resilience by enhancing their borrowing power and enabling them to spread local losses. The major chains survived unprecedented cost-control pressures in the late 1980s¹³⁶ although they entered this period in a highly leveraged financial position¹³⁷ and sustained heavy losses by their prepaid health plans. Meanwhile, many free-standing nonprofit hospitals were forced to close, while others were driven into dire states of indebtedness from which they have not yet

133. *Id.*; see also Nemes, *supra* note 22, at 27-30 (reporting a poor response by investor-owned chains to Medicare's introduction of prospective payment and to pressure on costs created by development of prepaid health plans). Inability to control costs adequately led Humana's major investor-owned competitors to abandon their fledgling prepaid health services ventures in the late 1980s.

134. *But cf.* Siegrist, *supra* note 130, at 43 (Wall Street analysts believe investor-owned chains benefit significantly from economies of scale in purchasing, service and equipment use, specialized design and construction assistance, and centralized functions such as accounting, data processing, risk management, and internal consulting.).

Some health administration specialists, though, argue that nonprofit hospitals can capture such economies of scale by forming their own multi-institutional networks. See, e.g., Kaiser, *supra* note 125, at 46; Larson, *supra* note 129, at 45, 49. Several studies suggest that any operating efficiencies and economies of scale achieved by the chains' centralized managements are more than offset by corporate headquarters' costs. See, e.g., J. Michael Watt et al., *The Comparative Economic Performance of Investor-Owned Chain and Non-For-Profit Hospitals*, 314 NEW ENG. J. MED. 89, 95 (1986); Pattison & Katz, *supra* note 131, at 352, 353; Lawrence S. Lewin et al., *Investor-Owned and Nonprofits Differ in Economic Performance*, HOSPITALS, July 1, 1981, at 52.

135. Dan Ermann & Joy Gabel, *Multihospital Systems: Issues and Empirical Findings*, 3 HEALTH AFF. 50, 56-58 (1984).

136. See *supra* text accompanying notes 21-33.

137. See Robert J. Buchanan, *The Financial Status of the New Medical-Industrial Complex*, 19 INQUIRY 308, 311, 313-14 (1982) (comparing debt/equity ratios for sixteen industry groupings, including the for-profit hospital chains; in 1980 the aggregate long-term debt/common equity ratio for thirteen of the largest hospital chains was 2.03, compared with a composite ratio of 0.269 for all the industries examined). This highly leveraged position reflected the intensive merger and acquisition activity in the late 1970s and early 1980s from which the major chains emerged.

recovered. However, a causal link between chain size and fiscal resilience has not been empirically demonstrated.¹³⁸

It is unquestionable, however, that some investor-owned chains have an edge in obtaining capital. High debt burdens, a shortage of assets available to pledge for secured credit, investor uncertainty about future reimbursement patterns, and a continuing relative decline in health philanthropy in comparison with other revenues handicap the nonprofit hospitals' efforts to obtain capital from traditional debt and donor sources. Moody's and Standard & Poor's have been unforgiving of nonprofit hospitals' financial weaknesses and uncertain revenue prospects. The resulting high interest rates for prospective bond issues have offset the advantage of tax exemption.

In contrast, most of the major investor-owned chains enjoy confidence in the financial markets even in the wake of the difficulties they endured in the late 1980s.¹³⁹ The industry leader, Humana, has impressed the financial community with the success of its vertical integration strategy¹⁴⁰ and achieved bond ratings in the BBB+ to A-range,¹⁴¹ which ensure ready access to public sources of capital. However, two other chains that executed leveraged buy-outs in 1989 are now awash in debt and weighed down by "junk" bond ratings.¹⁴² And the days when the imagined predictability of revenues from Medicare and other third-party payers justified highly leveraged financial positions in the minds of credulous Wall Street analysts¹⁴³ are gone. Not all of the major investor-owned chains today possess the financial strength and

138. Many complications would make such a demonstration difficult; I note only a few here. First, chain-owned hospitals tend to be located in areas less affected by the adverse hospital reimbursement developments of the 1980s than nonprofit hospital markets. Thus a direct comparison of closure rates or financial data would be meaningless. Also, distinguishing between the resiliency-enhancing effects of chain size and chain management practices is likely to be difficult.

139. See Highlights of Roundtable, *supra* note 31 (predicting that hospital chain stocks will be above-average market performers in the early 1990s and making "buy" recommendations for several).

140. Stroud, *supra* note 30 (quoting leading analyst's glowing praise for Humana's debt-to-equity ratio and success in the HMO market).

141. Other for-profit chains—such as National Medical Enterprises and Charter Medical Corporation—have won similar confidence from the financial markets through their success in developing specialty hospitals.

142. They are Hospital Corporation of America and American Medical International.

143. Siegrist, *supra* note 130, at 42. This perception of predictability reflected expectations of steady demand for hospital services, confidence that Medicare and Medicaid virtually guaranteed half the chains' revenue, and the companies' past ease in passing through expense increases via cost- and charge-based reimbursement mechanisms. *Id.* Hospital Corporation of America (HCA), the largest chain in the early 1980s, was for a time the nation's most highly leveraged "A"-rated industrial corporation. *Id.* (citing both Moody's and Standard and Poor's). In 1984, HCA was able to

credibility to tap the public debt and equity markets on behalf of academic medical centers' needs.

Vertical integration and market power are additional assets that an investor-owned chain can bring to bear on the management of teaching hospitals. Chain-owned community hospitals, nursing homes, and other medical facilities located near a newly acquired teaching center provide a ready-made patient "feeder" network for the center's beds and other tertiary care services. HMOs and other prepaid plans offered by the acquiring chain can become additional sources of patients.¹⁴⁴ Within the limits of emerging antitrust doctrine,¹⁴⁵ such a regional "hub and feeder" network is, by virtue of its market power and comprehensive "in-house" referral services, well poised to negotiate mutually favorable terms with large corporate buyers of health care.¹⁴⁶

C. NEW FINANCIAL SUPPORT FOR TEACHING AND RESEARCH

Sale proceeds or lease income, the most visible benefit of a deal with an investor-owned firm, are in theory available for any use. But if a sale agreement includes a "buy-back" option¹⁴⁷ (to protect the seller against

boast that its interest rate on a three-year financing was less than one half a percent above comparable federal obligations. HOSPITAL CORP. OF AMERICA, 1984 ANNUAL REPORT 22 (1985).

In 1983, while the Massachusetts General Hospital weighed HCA's offer to purchase McLean Hospital, a Harvard Medical School official calculated that McLean's projected need for \$35 million in capital could be met by HCA at a cost of \$23 per patient day, compared with \$36 if financed by tax-exempt debt. Telephone Interview with Ann Schwind, Director of Planning, Harvard Medical School (Oct. 1985); Faculty Advisory Committee Report, *supra* note 6. A senior HCA executive estimated in 1986 that one dollar in net earnings had the potential to generate \$30 in capital for the investor-owned chains, compared with only three dollars for the nonprofit sector. Egdahl, *supra* note 129, at 45 (quoting HCA Vice President and Treasurer Samuel Howard). Egdahl argues that the for-profit chains' greater potential for capital formation is by far their greatest attraction for academic centers. *Id.*

144. Humana has demonstrated the "feeder" potential of prepaid plans. In 1989, its hospital admissions rose by 4.6 percent in markets where its prepaid plans compete; by contrast, Humana hospital admissions in markets without Humana prepaid plans were down by 1.2 percent. Valeri Oliver, *HCA, Humana Have Different Outlooks*, NASHVILLE BUS. J., Nov. 13, 1989, § 1, at 20.

145. See *infra* text accompanying notes 396-411.

146. Cf. Jeff Goldsmith, *A Radical Prescription for Hospitals*, HARV. BUS. REV., May/June 1989, at 107 (predicting that the economically successful hospital of the future will function as a critical-care hub for a dispersed network of clinical and social services tied together by health insurance plans).

147. For example, the agreement by which American Medical International, Inc. (AMI) acquired the St. Joseph's Hospital, Creighton University's principal teaching facility, grants either the university or a foundation created from sale proceeds the right to repurchase the hospital if AMI reneges on certain commitments to academic activities and indigent care. Richard L. O'Brien, *The Decision-Making Process*, in THE INVESTOR-RELATED ACADEMIC HEALTH CENTER: AN UNCERTAIN COURTESHIP 192, 199 (1986).

subsequent developments it deems inimical to the teaching hospital's academic mission¹⁴⁸), the sale principal must be preserved in order to maintain the option's credibility.¹⁴⁹ Still, income from the principal can be applied to the support of mission-related activities,¹⁵⁰ either by employing the proceeds as new university endowment or, in the case of a nonuniversity seller, creating an independent foundation.¹⁵¹

Another basis for financial gain is less visible. Ownership or lessorship of a major teaching hospital has certain unique economic advantages for an investor-owned chain¹⁵²—advantages not realizable by a free-standing nonprofit owner such as a university. A nonprofit seller or lessor, however, can obtain additional consideration from its for-profit negotiating partner in exchange for these advantages. This consideration can take the form of a commitment to provide direct financial support for academic activities—by endowing faculty positions,¹⁵³ providing a yearly subsidy for teaching and research, or simply paying a higher rent or sale price.

In addition, a university seller or lessor can enrich its revenue stream from faculty practice by bargaining for a corporate commitment to a faculty role in the provision of clinical consultation services to the chain's other facilities.¹⁵⁴ Moreover, faculty can generate a new revenue

148. See *infra* text accompanying notes 569-82.

149. See Egdahl, *supra* note 129, at 49 (warning that depletion of principal could make it impossible to both execute a buy-back and fund the missions not maintained by the for-profit firm); Philip Birnbaum, Dean for Administrative Affairs, George Washington University Medical Center, Remarks at Symposium (Feb. 20-22, 1985), in *THE INVESTOR-RELATED ACADEMIC HEALTH CENTER AND MEDICAL EDUCATION: AN UNCERTAIN COURTSHIP* 63 (1986) (Spending of sale principal threatens the "ability to maintain flexibility.").

150. Some warn, however, that failure to apply income toward the accrual of a larger corpus could endanger the viability of a buy-back option in the event of high inflation. See, e.g., Stanley Bergen, President, University of Medicine and Dentistry of New Jersey, Remarks at symposium (Feb. 20-22, 1985), in *THE INVESTOR-RELATED ACADEMIC HEALTH CENTER AND MEDICAL EDUCATION: AN UNCERTAIN COURTSHIP* 65 (1986).

151. Tatge, *supra* note 19.

152. See *infra* text accompanying notes 171-228 (discussing the usefulness of teaching hospital operations in horizontal and vertical expansion strategies).

153. For example, in its 1983 proposal to purchase McLean Hospital, HCA offered to permanently endow five psychiatry professorships at McLean. Faculty Advisory Committee Report, *supra* note 6, at 8.

154. See Dennis S. O'Leary, *Practice Plan, Allied Health Professions Education, and Continuing Medical Education*, in *THE INVESTOR-RELATED ACADEMIC HEALTH CENTER AND MEDICAL EDUCATION: AN UNCERTAIN COURTSHIP* 94, 96-105 (1986) (discussing prospects for increased faculty referrals if an academic medical center develops into a regional hub within a vertically integrated, for-profit system).

stream for the support of teaching and research¹⁵⁵ by selling technology-transfer services to other chain facilities—for example, by offering continuing medical education and allied health training programs at these sites.

D. EXPANDED ACADEMIC PROGRAM OPPORTUNITIES

New research and teaching opportunities do not appear to be a major motivating factor for teaching centers interested in sale and lease arrangements. But participation in a large, vertically integrated health care system offers academic managers some attractive possibilities. One obvious asset is a new pool of academically “interesting” referral patients. Additionally, a chain’s network of community hospitals, long-term inpatient facilities, and ambulatory care sites offers a diverse array of opportunities for student and resident training outside the traditional, tertiary care setting.¹⁵⁶ There are tempting research possibilities as well. Corporate commitment to developing an academic center as a tertiary care “flagship” would likely bring a new influx of capital for the acquisition of advanced technology, creating new investigative opportunities. Access to a for-profit chain’s vast patient database and sophisticated, multicenter clinical data management system would be an invaluable tool for large-scale clinical and epidemiologic studies.¹⁵⁷ Moreover, patients throughout a for-profit system could be included in research protocols designed at the teaching center.¹⁵⁸

In short, for financially troubled teaching centers facing an uncertain environment, the sale or lease of hospital operations to an investor-owned chain is an appealing, albeit not economically risk-free, option. But there are also some serious nonfinancial risks for the maintenance of academic missions within the context of the resulting partnership. These risks arise from inevitable tensions between the concerns of corporate managers and those of academic leaders. Some argue that conflicts of interest are irreconcilable—and so serious that such unorthodox partnerships ought never to be formed. These critics hold that the very presence of for-profit enterprise in health care delivery, especially in association with medical teaching and research, is objectionable. Moreover, sale or

155. *Id.* at 95-96. O’Leary warns, however, that such a technology transfer program, along with expanded faculty practice, could unduly divert faculty attention from teaching students and doing research. *Id.* at 96, 102.

156. *Id.* at 102-03.

157. *See, e.g.*, Faculty Advisory Committee Report, *supra* note 6, at 8 (extolling the value of HCA’s clinical database and data management system for psychiatric research at Harvard).

158. *Id.*

lease of a teaching hospital to a for-profit corporation raises numerous legal and regulatory questions.

Before addressing these issues, however, I will consider the needs and management strategies which have led the major investor-owned hospital chains to become interested in leasing and acquiring teaching hospitals. Armed with an understanding of the for-profit hospitals' objectives, one can better assess both the hazards of such arrangements for academic centers and the potential of negotiations to reduce the risk.

IV. THE NEEDS AND STRATEGIES OF THE INVESTOR-OWNED HOSPITAL CHAINS

A. BACKGROUND: EXPLOSIVE GROWTH AND FUTURE EXPECTATIONS

The phenomenal growth of the big, for-profit health care delivery corporations is largely a product of permissive third-party payment for hospital services. Prior to the rapid expansion of cost- and charge-based insurance coverage in the 1960s and 1970s, proprietary hospitals had long played a role in the American health care economy by virtue of their ability to respond more quickly than nonprofits to rises in demand.¹⁵⁹ Typically, they were transitional forms, founded by physicians or other small investors where population growth generated demand in excess of nonprofit hospital capacity.¹⁶⁰ They had an edge over nonprofit hospitals in meeting rising demand because their ability to pay a return on equity enabled them to raise capital more quickly. But where demand stabilized, nonprofit hospitals seemed to have a competitive edge, perhaps because of patient and physician distrust for the profit motive.¹⁶¹ Thus, typically, for-profit facilities in areas with stable demand sold out to nonprofit entities.¹⁶² As the nation's population growth slowed, proprietary hospitals' market share ebbed, from more than a third of all hospitals in 1928 to eleven percent by 1968.¹⁶³ But the inception of Medicare and the proliferation of private insurance in the 1960s triggered a nationwide demand explosion and transformed the proprietary hospitals' fate.

159. Bruce Steinwald & Duncan Neuhauser, *The Role of the Proprietary Hospital*, 35 L. & CONTEMP. PROBS. 817, 824 (1970).

160. *Id.* at 82.

161. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 950 (1963).

162. Steinwald & Neuhauser, *supra* note 159, at 825.

163. *Id.* at 819.

Suddenly, they became very lucrative businesses, especially in states where many patients carried charge-based commercial insurance¹⁶⁴ and legislatures had not enacted rate regulation. Perceptive entrepreneurs began acquiring free standing proprietary hospitals, usually by offering stock to the owners of target facilities. By 1970, twenty-nine corporations owned two or more hospitals. The largest of these owned thirty-one.¹⁶⁵ When some of these firms floated public equity offerings, investor confidence in the dependability of third party payment sent their stock prices soaring. This enhanced the ability of the nascent chains to acquire independent proprietaries in exchange for new stock. The chains grew rapidly, yet their expansion was confined almost exclusively to the for-profit sector.¹⁶⁶ By 1977, corporate chains owned ninety percent of all for-profit hospitals.¹⁶⁷ But trustees and managers of financially successful voluntary hospitals had little incentive to sell—and thereby give up their own authority and autonomy. Financially troubled nonprofit hospitals, meanwhile, were unattractive takeover targets.

The larger chains, though, maintained their explosive growth, something the investment community had come to expect, by turning in the late 1970s to acquisitions of other multihospital systems.¹⁶⁸ By 1981, after an intense round of often unfriendly takeover activity, three huge firms—HCA, Humana, and American Medical International (AMI)—stood astride the for-profit field, controlling nearly seventy-five percent of all chain-owned beds.¹⁶⁹ Analysts were predicting continued rapid growth,¹⁷⁰ and the firms' stock prices reflected these expectations.

164. Cf. Carson W. Bays, *Patterns of Hospital Growth: The Case of Profit Hospitals*, 21 MED. CARE 850 (1983) (reporting that data for 1971 to 1977 show strong correlations between regional rises in for-profit hospitals' market share and growth in commercial hospital insurance and in the size of the Medicare-eligible population).

165. Steinwald & Neuhauser, *supra* note 159, at 831. The twenty-nine owned 207 hospitals, about a quarter of the country's proprietaries. The largest, at thirty-one hospitals, was American Medicorp, Inc. (subsequently swallowed up during a round of mergers and acquisitions). HCA owned twenty-three. *Id.*

166. Gray, *supra* note 11, at 10-11.

167. Bays, *supra* note 164, at 856 (citing American Hospital Ass'n data).

168. Siegrist, *supra* note 130, at 45-47.

169. Donald E.L. Johnson & Vince DiPaolo, *Multihospital System Survey*, MOD. HEALTHCARE, Apr. 1981, at 80.

170. STARR, *supra* note 42, at 435 (quoting predictions that the for-profit chains would double in size during the 1980s despite little growth in the hospital industry overall).

B. HORIZONTAL EXPANSION STRATEGIES

By the early 1980s, however, the chains had largely exhausted the possibilities of horizontal integration within the for-profit sector. Moreover, they had made only minimal progress toward penetrating the voluntary and public sectors.¹⁷¹ They could continue their horizontal growth only by moving beyond the existing for-profit field. The nation's religious and secular voluntary hospitals, facing mounting competitive pressures, seemed the next logical takeover targets. The chains were also drawn to the development of new inpatient facilities specializing in psychiatric illness, substance abuse, and rehabilitation medicine—fields for which third-party payment to hospitals remained generous relative to actual inpatient care costs.

Some advocates of competition in health services predicted at the time that market forces, abetted by procompetitive reform, would eventually transform the hospital industry into a predominantly for-profit endeavor.¹⁷² They envisioned that one day a few nationwide, investor-owned systems would dominate the health services market, opposing each other within different localities by means of competing networks of "feeder" physicians, specialty and community hospitals, and tertiary care "hubs." The market, they believed, would accomplish the economic rationalization of health care¹⁷³—a goal that had eluded federal and state health planning agencies.

The second half of the 1980s proved these predictions wrong, at least in the short term. Under competitive conditions in which market enthusiasts had expected investor-owned systems to thrive, the for-profits failed to sustain their prior rates of growth.¹⁷⁴ They responded slowly to mounting cost-control pressures from third-party payers, suffered hundreds of millions of dollars in losses when they began offering prepaid

171. Investor-owned firms, however, had management contracts with more than one hundred acute care voluntary hospitals (and eighty publicly owned acute care facilities) by the end of 1981. Jeffrey Alexander & Bonnie L. Lewis, *The Financial Characteristics of Hospitals Under For-Profit and Nonprofit Contract Management*, 21 INQUIRY 230, 233 (1984). The firms' management contracts with freestanding proprietary facilities have often preceded acquisitions. *Id.*

172. See, e.g., David A. Stockman, *Premises for a Medical Marketplace: A Neoconservative's Vision of How to Transform the Health System*, 1 HEALTH AFF. 5, 16 (1981).

173. See Christopher Pollitt, *Corporate Rationalization of American Health Care: A Visitor's Appraisal*, 7 J. HEALTH POL., POL'Y & L. 227 (1982) (critiquing federal policies that, through regulatory and market-oriented means, have pursued bureaucratic "rationalization" of medical care by private sector organizations).

174. See *supra* text accompanying notes 21-22 (discussing poor performance in the face of Medicare's prospective payment system, competition between prepaid health plans, and mounting pressure from large employers concerned about medical costs).

health plans, and saw their stock prices dip sharply¹⁷⁵ as investors abandoned expectations of continuing rapid growth.¹⁷⁶ Managers took two of the four largest chains private via leveraged buyouts, incurring massive "junk" debt that precluded major acquisitions before the early to mid-1990s.¹⁷⁷ All but one of the major chains abandoned their nascent prepaid plans.

But by 1990, the major chains had weathered the storm and were again eyeing horizontal growth opportunities. Humana, the firm that had stood by its vertically integrated, prepaid plans, had become the industry leader and was looking to enter new markets.¹⁷⁸ National Medical Enterprises (NME), which had sustained increases in profits through the 1980s due to its success with specialty hospitals, continued to build and buy psychiatric and rehabilitation facilities.¹⁷⁹ The two firms that went private—HCA and AMI—were meeting their leveraged buyout debt obligations. Financial analysts predicted that the two would retire this debt ahead of schedule and be in position by the mid-1990s to pursue new acquisitions.¹⁸⁰

1. *The Problem of Credibility*

The explosive growth enjoyed by the for-profit systems from the late 1960s through the early 1980s is unlikely to resume. Renewed horizontal growth in the 1990s will probably be more selective. Humana's success with prepaid health plans and its interest in new markets indicate one likely avenue for such growth: acquisition of community hospitals well situated to support vertically integrated plans in new markets.¹⁸¹ The success of NME and other chains in the specialty hospital field suggests another: continued construction and acquisition of psychiatric, substance abuse, and rehabilitation medicine facilities. Recent legislation in some

175. Humana, the industry leader today, saw its share price drop from the mid-thirties in 1986 into the teens in 1987, after a seventy-five percent drop in net earnings in 1986. Stroud, *supra* note thirties, at 1.

176. *Id.*

177. See *supra* text accompanying note 26.

178. See *supra* text accompanying notes 29-30.

179. See Green & Nemes, *supra* note 28, at 37.

180. See Nemes, *supra* note 22.

181. Humana is likely to pursue such acquisitions. Should other for-profit systems seek to duplicate Humana's successful vertical integration strategy, acquisitions of community, nonprofit hospitals by investor-owned systems could become an important industry trend in the 1990s.

states requiring employers to include minimum psychiatric and substance abuse benefits in their employee health insurance packages¹⁸² has enhanced growth opportunities for investor-owned systems in these fields.

More speculatively, the chains might move to acquire a substantial number of nonprofit community hospitals outside the framework of vertical integration strategies if Congress acts to make health insurance more broadly available. Several comprehensive, federally supported insurance plans now under congressional consideration¹⁸³ would transform many community hospitals now struggling under the burden of uncompensated care into profitable ventures attractive to investor-owned chains. Should Congress find the high cost of universal coverage plans prohibitive,¹⁸⁴ more modest measures—such as expansion of Medicaid eligibility and benefits¹⁸⁵—would still be a boon for hospitals with high percentages of indigent patients.

182. See, e.g., MASS. GEN. LAWS ANN. ch. 175, § 47(b) (West 1991). In addition, recent court decisions have construed private health insurance contracts to require more generous reimbursement for some inpatient psychiatric services than had traditionally been provided. See, e.g., *Arkansas Blue Cross & Blue Shield, Inc. v. Doe*, 733 S.W.2d 429 (Ark. Ct. App. 1987) (holding that a plaintiff with bipolar disorder could recover benefits provided by an insurer for physical conditions rather than being limited to the lesser reimbursement for mental conditions); *Kunin v. Benefit Trust Life Ins. Co.*, 898 F.2d 1421 (9th Cir. 1990) (holding that the plaintiff's autistic son was entitled to recover from the insurer the amount in excess of the limit for "mental conditions").

183. Congressional Democrats have proposed several competing universal health insurance models. Two such plans call for a single-payer government insurance program modeled on the Canadian approach. S. 1146, 102d Cong., 1st Sess. (1991); H.R. 1300, 102d Cong., 1st Sess. (1991). A second model, commonly known as the "pay or play" strategy, would require employers to either provide their employees with health insurance or to contribute a percentage of their payrolls to a public insurance program. The public plan would then provide coverage to the employees of contributors and to the unemployed. E.g. S. 1227, 102d Cong., 1st Sess. (1991); H.R. 3205, 102d Cong., 1st Sess. (1991). The "pay or play" proposals now pending in Congress are variations on the universal insurance plan proposed in 1990 by the U.S. Bipartisan Commission on Comprehensive Health Care (Pepper Comm'n). PEPPER COMM'N, A CALL FOR ACTION (1990).

184. The Pepper Commission's universal insurance plan would have required an additional \$24 billion in new federal revenues in 1990, *id.* at 69, a tax bite exceedingly unlikely to inspire enthusiasm among legislators preoccupied by the difficulties of federal deficit reduction.

185. Senate Republicans have proposed incremental reform of the existing health care system as an alternative to a universal insurance plan. The Health Equity and Access Improvement Act of 1991, sponsored by Senator John Chafee, offers tax credits to families whose total income is less than thirty-two thousand dollars per year. The plan also proposes tax deductions for those who are required to buy their own health insurance. Because persons currently receiving health insurance as part of their employment compensation package are not required to pay taxes on monies contributed by their employers toward insurance premiums, allowing individuals who do not receive insurance through their employers to deduct the premiums would lead to greater equity in the tax code. The proposal would also create a public program for those not eligible for Medicaid but with income levels below two hundred percent of the federal poverty level. S. 1936, 102d Cong., 1st Sess. (1991).

To pursue these horizontal growth opportunities, investor-owned chains must gain the confidence of a range of actors critical to the success of new inpatient ventures. These include community hospital board members, local community and political leaders, hospital unions, corporate health benefits managers, physicians, and potential patients. Their support will be essential to for-profit systems' efforts to gain hospital board approval for leasing or acquisition deals, to obtain necessary regulatory approvals, and to market new services. The investor-owned systems have looked to involvement with academic medicine as a means for achieving credibility in the eyes of these important decision makers.

2. *An Answer: The Appeal of Academic Affiliation*

The for-profit chains' interest in acquiring or leasing teaching hospitals arose in the early and mid-1980s as the firms searched for ways to sustain their extraordinary growth. The chains saw two classes of advantage in owning or operating teaching facilities in partnership with academic institutions: (1) enhanced prestige and (2) the ability to offer specialized services and expertise. Although the major chains now harbor more selective ambitions for horizontal growth, these advantages retain their strategic appeal.

a. *Enhanced prestige:* During the early years of the twentieth century, scores of profit-making, low-budget medical schools flourished in an unregulated environment, turning out large numbers of poorly trained graduates. Concerned about the profession's low prestige and earning power, the American Medical Association (AMA) embarked in 1904 on a campaign to raise standards sufficiently to put these enterprises out of business. Armed with a scathing 1910 report by the elite Carnegie Foundation (the Flexner Report) documenting inadequate facilities and rampant fraud at the proprietary schools, the AMA won wide acceptance among the states for its proposed minimum accreditation standards. Unable to upgrade their facilities and still turn a profit, proprietary schools closed down en masse. Some were acquired by nonprofit, university-affiliated colleges of medicine. Between 1906 and 1922, the number of medical schools declined by half.¹⁸⁶

The proprietary schools bequeathed to medicine a lingering perception of the for-profit form as associated with mediocrity or worse. This

186. STARR, *supra* note 42, at 116-23. By 1922, the number of American medical schools had dropped to eighty-one, from 160 in 1906. *Id.*

image has been reinforced by the stereotype of the small proprietary hospital founded by physicians who are unable to obtain admitting privileges elsewhere.¹⁸⁷ Today's investor-owned chains are heirs to this stigma. But by making a commitment to support academic excellence in medicine, the chains can project a powerful contrary image. Arguably, the chains could accomplish this through a program of large philanthropic contributions to nonprofit academic centers. Philanthropy alone, however, cannot convey the message about excellence the chains would most like to get across—that the for-profit form, in its modern, corporate incarnation, can breed its *own* excellence within. A chain can deliver this message directly by making a long-term commitment to academic excellence within its operating system—for example, by owning or leasing a major teaching center and maintaining or even enhancing its quality.

Announcement of such a commitment can yield some short-term public relations value, particularly if the academic program concerned has national or regional prestige.¹⁸⁸ But the targeted recipients of the message—voluntary hospital trustees, physicians, and civic leaders whose confidence is essential for chain expansion into the nonprofit sector—are unlikely to be won over by public relations alone. Entrusting a community hospital to a for-profit chain is not an impulsive decision easily influenced by an advertising pitch; it is the outcome of a process of considered judgment, involving multiple constituencies potentially affected by the change.¹⁸⁹ If corporate commitment to research and teaching is to affect this judgment, it must be serious over the long haul—serious enough to withstand the critical scrutiny of potential sellers or lessors, and of constituencies with influence over their decision.

187. Bays, *supra* note 164, at 850.

188. The outstanding example is Humana's Jarvik-7 artificial heart program. Humana "acquired" the financially struggling program from the University of Utah in 1984 by luring surgeon William DeVries with a promise to fund up to one hundred implants so long as the program yielded "scientific progress." HUMANA, INC., *HUMANA AND THE ARTIFICIAL HEART* (1985). The result was an unprecedented period of publicity for Humana as reporters from the television networks and leading newspapers flocked to Louisville to receive daily progress briefings on the Humana Heart Institute's first several implant patients. Humana has hardly been shy about its motives. David Jones, the firm's chairman and chief executive officer, recently boasted to investors about the implant program's importance for the firm's promotional strategy—winning recognition for the name "Humana" as "a national brand." Presentation by David Jones to the A. G. Edwards & Sons, Inc., Conference on Investing in the Midwest (Oct. 2, 1985) (on file with the Humana, Inc., Dept. of Public Affairs) [hereinafter Presentation by David Jones].

189. See Jessica Townsend, *When Investor-Owned Corporations Buy Hospitals: Some Issues and Concerns*, in *THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT* 51 (Bradford H. Gray ed., 1983) (presenting a study of decision-making processes and concerns of affected parties for four voluntary and county-owned community hospitals purchased by investor-owned chains in 1981).

Key decision makers must be convinced that the commitment is an expression of corporate personality,¹⁹⁰ not merely a public relations facade.

b. *Specialized services and expertise:* When it operates a major teaching hospital, a chain has at its disposal a large reservoir of highly specialized expertise. The chain can draw upon this expertise in developing programs for its community hospitals and other facilities. Possibilities include clinical consultations, specialized laboratory services, and continuing education programs for community physicians and allied health professionals. For physicians and hospital board members considering a sale or lease, access to such programs may be an added attraction. For the chain, concentration of certain costly, highly specialized, and infrequently used clinical services in a single place—the teaching hospital—is a cost-effective way to provide them for local facilities that might otherwise have to do without them.¹⁹¹

Similarly, well-established access for particularly ill or complicated patients to a teaching hospital's tertiary-care beds may strengthen a community hospital's ability to serve its locality's needs.¹⁹² This could appeal both to potential sellers and to those community physicians who have a choice about where to hospitalize their patients. When a chain operates both community and tertiary care hospitals within a region, it can rationally place patients in the least costly facility that meets their needs. This is a powerful attraction in the new world of prospective payment and integrated, prepaid health plans.

C. THE VERTICAL INTEGRATION STRATEGY

In the early 1980s, Humana became the first of the chains to reorient its growth strategy away from hospital acquisitions toward vertical integration. Sensing that cost control pressure from employers, private

190. Cf. TOM PETERS & NANCY AUSTIN, A PASSION FOR EXCELLENCE: THE LEADERSHIP DIFFERENCE 98-106 (1985) (Passionate, consistent organizational commitment to quality across-the-board is vital for preserving high morale and engendering customer confidence.).

191. See Jeff Goldsmith, *A Radical Prescription for Hospitals*, HARV. BUS. REV., May/June 1989, at 104 (urging health care organizations to economize by concentrating tertiary, acute care services in a small number of regional, high technology centers).

192. Of course, community hospitals can forge such links with tertiary care centers without becoming part of for-profit, multi-hospital systems. Major teaching centers typically maintain loose ties with a network of free-standing community facilities. These ties, often sought by community hospitals interested in enriching their educational programs, frequently lead to patient referrals.

insurers, and the federal government placed new demands on providers—demands most effectively met by vertically integrated organization¹⁹³—the firm began to refashion itself as a network of comprehensive care delivery systems.¹⁹⁴ To lay the groundwork, Humana negotiated affiliations with doctors along the lines of the “Preferred Provider Organization” (PPO) model.¹⁹⁵ The company promoted its hospitals, other facilities, and affiliated physicians as an integrated service system;¹⁹⁶ it then marketed an insurance vehicle with a national brand name, “Humana Care Plus,” to employers at rates below those for traditional insurance.¹⁹⁷ Humana Care Plus permitted subscribers to choose nonaffiliated hospitals and doctors, but it provided much more liberal benefits for patients who selected Humana hospitals and plan-affiliated physicians.

Humana’s major investor-owned competitors put similar prepaid plans on the market in 1985.¹⁹⁸ These plans lacked Humana’s intensive monitoring of clinical decisionmaking, which was considered necessary by industry observers to keep costs competitive,¹⁹⁹ and they were abandoned within a few years. But Humana’s eventual success²⁰⁰ with this

193. Some health services researchers predicted in the 1970s that the cost control imperative would catalyze a switch to vertical integration. Horizontal expansion, they argued, was a rational response to the incentives of cost-plus reimbursement, but it had little potential to produce the savings demanded by the new cost control ethos. Only vertical integration and the introduction of comprehensive, prepaid medical care plans could produce substantial cost reductions. *See, e.g.* Stephen M. Shortell, *The Researcher’s View, in HOSPITALS IN THE 1980s: NINE VIEWS* (1977) (collection of articles published by the American Hospital Association). The demonstrated ability of HMOs to cut costs substantially by holding down hospital use supported Shortell’s prediction, assuming a rational market response to cost control pressure. But some, including Paul Starr, cautioned that health care organizations threatened by cost control pressure could obtain, in the political arena, protections that would obviate the need to economize. STARR, *supra* note 43, at 442.

194. Jennifer Bingham Hull, *Medical Turmoil: Four Hospital Chains, Facing Lower Profits, Adopt New Strategies*, WALL ST. J., Oct. 10, 1985, at 1.

195. Under the PPO model, doctors in private, fee-for-service practice agree to provide services at a discount for subscribers to a health insurance plan. Though subscribers may choose either affiliated or non-affiliated physicians, the plan’s fee-for-service reimbursement schedule pays higher rates to affiliated doctors (who are contractually obligated not to bill subscribers for amounts greater than the fees set by the PPO). The affiliated physician who agrees to the plan’s discounted fee schedule gains access to the PPO’s patient pool. For the plan, the market power flowing from large numbers of subscribers make possible the purchase of fee-for-service care at a discount.

196. Presentation by David Jones, *supra* note 188.

197. Hull, *supra* note 194.

198. Martin Tolchin, *Private Hospitals Are Now Offering Health Insurance*, N.Y. TIMES, July 5, 1985, § A, at 1.

199. *See supra* text accompanying note 132-34. Besides Humana, the only vertically integrated health services organization to achieve such cost-containment on a national scale is Kaiser Permanente, a nonprofit chain of HMOs. Stroud, *supra* note 30, at 1.

200. Success was hardly immediate; Humana’s prepaid plans suffered huge losses during their first several years, including a \$129 million loss in 1986. *Id.*

concept²⁰¹ has proven its tremendous potential. Thus far, Humana's success and ambitious plans for future vertical growth have not inspired rivals to try again. But one or more may, particularly if Congress acts to require expanded employer or public financing (or both) for health services.

1. *The Potential Role of Academic Medical Centers*

For the vertically oriented approach, long-term commitments to teaching hospitals, via purchase or leasing deals, offer advantages similar to those for horizontal growth strategies. By integrating programs of academic excellence into their vertical systems, the chains can nurture perceptions that their "brand names" represent quality and prestige. Moreover, by including a teaching center's specialized capabilities within a prepaid health plan, a chain can extend the savings of vertical integration to tertiary services—such as inpatient referrals, clinical consultations, and specialized laboratory studies—for which it might otherwise need to hire (on a fee-for-service basis) outside consultants and contractors. A teaching center's potential as a source of training programs for medical and allied health personnel is attractive under vertical and horizontal growth strategies.

However, the marketing role of teaching center involvement may differ significantly under horizontal and vertical approaches. The difference lies in the identity of the actors whom the firm's promotional efforts aim to influence. Promotional strategy for horizontal growth must target (1) those with a role in a free standing hospital's decision to sell, and (2) those who determine which hospital an inpatient selects (typically, fee-for-service physicians). For a vertical approach, the critical targets are the buyers of comprehensive, prepaid plans—generally employers, who may be influenced by feedback from employees. The targets of the horizontal strategy, nonprofit hospital trustees and administrators, community leaders, and physicians, are likely to scrutinize a chain's claims closely, with a sophisticated eye toward distinguishing between genuine commitment to quality and promotional facade.²⁰² The managers of employers in the market for prepaid, comprehensive plans may be less able or inclined to investigate, preoccupied as they are by the imperatives of cost reduction. They may thus be more vulnerable to a hospital chain's exploitation of an academic program's prestige for promotional

201. See *supra* text accompanying notes 132-34.

202. See *supra* text accompanying notes 188-90.

purposes, without real commitment to maintaining that program's excellence.

In the long run, however, it would be strategically unwise for a chain to milk an academic program's prestige without preserving its quality. Given the outspokenness of academics,²⁰³ the word would ultimately get out and the chain's reputation (and marketability) would be sullied. But under the immediate pressure of today's wide-open competition between prepaid plans, a chain could succumb to short-term temptation.²⁰⁴ A teaching center's leadership ought to be aware of this hazard as it negotiates postsale or postlease protections for academic programs.

Yet the center's negotiators should also remain aware that an acquiring chain's long-term interests are best served by serious and sustained commitment, not economic rape, even in the new climate of intense competition between prepaid plans. To take full business advantage of an academic center's prestige and expertise, an investor-owned chain must win, then hold, the confidence of its faculty. Chain executives at least claim to understand this.²⁰⁵ In presentations to academic administrators, they have emphasized their willingness to subsidize tertiary services that operate at a loss. They have argued that this makes good financial sense because these services provide clinically necessary support for a profitable, vertically integrated, comprehensive care system within a region.²⁰⁶

This kind of pragmatic business rationale will dictate chain decisions about teaching hospital acquisitions. Though some observers in the mid-1980s predicted a large wave of teaching center takeovers, a limited number of highly selective purchase and leasing bids is more likely.²⁰⁷

203. See, e.g., *supra* text accompanying notes 2-6.

204. It might even be economically rational in the long run for a chain to pursue such an exploitative marketing strategy. If quick, disingenuously-achieved success in the promotion of its prepaid plans drove significant competitors out of its markets, a chain could then pare costs (and boost profits) by reducing support for academic programs, without risk of losing subscribers unless significant competitors re-entered its markets.

205. See, e.g., Remarks by David Rollo, Humana, Inc., Senior Vice President for Medical Affairs, *reprinted in* THE INVESTOR-RELATED ACADEMIC HEALTH CENTER AND MEDICAL EDUCATION: AN UNCERTAIN COURTSHIP 120 (1986) [hereinafter Remarks by Rollo].

206. See, e.g., *id.* at 134; Remarks by David Williamson, HCA Executive Vice President for Development, *reprinted in* THE INVESTOR-RELATED ACADEMIC HEALTH CENTER AND MEDICAL EDUCATION: AN UNCERTAIN COURTSHIP 133 (1986).

207. Five years ago, when the for-profit systems' expansion plans were more ambitious than they are today, John Moxley, a senior AMI executive responsible for his firm's arrangements with academic centers, predicted that by 1995 the chains would become involved (via purchase or lease) with no more than twenty major teaching hospitals by 1995. Remarks by John Moxley, AMI Senior Vice President and Director of Corporate Strategic Planning and Alternative Services, *reprinted in*

Academic centers, like any other acquisitions, will need to fit into the vertical integration strategy.²⁰⁸

2. *The AMI Paradigm*

In the mid-1980s, AMI developed a comprehensive approach to the problem of reconciling an academic center's needs with the imperatives of vertical integration. The firm created a separate unit concerned exclusively with relations between the firm and academic centers,²⁰⁹ cultivated a benevolent image with teaching hospital administrators, and stated its intention to make teaching centers into "regional hubs" in a nationwide, comprehensive care network.²¹⁰ Even more, AMI indicated an interest in making teaching centers its partners in the design, development, and staffing of regional care delivery systems.

AMI articulated this approach most fully during talks with George Washington University in 1985 about a possible purchase or lease of the university's hospital. AMI urged that any sale or lease be made part of a broader arrangement between the university and the company for the

THE INVESTOR-RELATED ACADEMIC HEALTH CENTER AND MEDICAL EDUCATION: AN UNCERTAIN COURTSHIP 114, 117 (1986).

There are about 150 to 175 major teaching hospitals (institutions with residency programs in most fields and more than one hundred house staff) affiliated with the nation's 127 medical schools. About sixty are owned by universities (both public and private); the remainder are owned by a variety of government and private entities. Ruth Hanft, *For-Profit Hospitals: The Implications for Teaching and Research* (Oct. 4, 1984) (unpublished paper, presented to the George Washington University 1984 Harold and Jane Hirsh Symposium, on file at the Institute of Medicine, Division of Health Care Services).

208. See, e.g., Remarks of Marvin Dunn, AMI Vice President for Academic Medical Centers, reprinted in *THE INVESTOR-RELATED ACADEMIC HEALTH CENTER AND MEDICAL EDUCATION: AN UNCERTAIN COURTSHIP* 168 (1986) (AMI's plan in the mid-1980s for a single major tertiary care center in each region—"an academic medical center is a perfect example"—to "anchor" the company's "vertically integrated health care system" within the region). Although AMI's insurance losses in the late 1980s and a subsequent leveraged buyout by management cut short its vertical integration program, the role AMI envisioned for academic centers represents a model for vertical integration in the 1990s.

209. The unit is headed by two former medical school deans, John Moxley III, Senior Vice President and Director of Corporate Strategic Planning and Alternative Services (formerly Assistant Secretary of Defense for Health Affairs, and Dean at the University of Maryland and University of California at San Diego Schools of Medicine); and Marvin Dunn, Vice President for Academic Medical Centers (formerly Dean of the University of Texas Medical School at San Antonio).

210. See, e.g., Letter from AMI Senior Vice President John Moxley III & Group Vice President Keith Weikel to Philip Birnbaum, George Washington University Medical Center (GWUMC) Dean for Administrative Affairs app. III at 19 (Sept. 20, 1984) (on file at the GWUMC Office of the Dean for Administrative Affairs) [hereinafter *AMI Letter*]. This document, part of a joint AMI/GWUMC study of the feasibility of a purchase or leasing deal, stated that "AMI's principal strategic thrust over the next five years" would be the development of a network of such "regional hubs," each linked to community hospitals and a variety of ambulatory care facilities. *Id.*

joint development of a vertically integrated system.²¹¹ Initially, the system was to include a faculty-staffed HMO²¹² and area community hospitals operated by AMI. AMI envisioned the eventual joint development of an expanded ambulatory care network, a home care project, and new teaching and referral links with the region's community hospitals.²¹³ With promotional and financial support from AMI corporate headquarters, the system was to market a variety of prepaid, comprehensive care plans to employers and individuals in the Washington, D.C. metropolitan area. AMI proposed to delegate operating authority over the system to a seven-member governing board with a four to three university majority.²¹⁴ The university agreed in principle to the concept of a regional network and the governing board arrangement.²¹⁵

After inviting competing proposals from other investor-owned systems, the university entered a second round of more intensive and detailed talks with AMI.²¹⁶ Company officials spoke of George Washington as a model for the relationships the firm hoped to develop with teaching centers elsewhere—relationships that would make academic centers the keystones of AMI's vertical integration strategy. But in 1986, in the face of mounting financial difficulties, AMI began to reevaluate its vertical integration plans. The firm broke off negotiations with George Washington in late 1986²¹⁷ and abandoned the vertical integration concept a year later.²¹⁸ Nevertheless, the AMI paradigm retains promise for investor-owned systems interested in vertical integration.

For teaching hospital administrators, the AMI model holds promise as a way to benefit from the financial, management, and marketing

211. *Id.* at 2, app. III at 10-11.

212. The university had owned and operated the HMO for twelve years. In an action which university officials characterized as "separate" from their talks with AMI about possible sale or lease of the hospital, the university issued a "Request for Proposals" for purchase or development of a joint venture with the HMO. AMI's efforts to broaden its discussions with George Washington included a bid on the HMO and an expression of interest in the university's highly successful faculty practice plan. O'Leary, *supra* note 154, at 96-97.

213. AMI Letter, *supra* note 210, app. III at 10-11.

214. *Id.* app. I at 8. The Board was to be chaired by George Washington University's Vice President for Medical Affairs and to include the medical school's three deans for Administrative, Clinical, and Academic Affairs, plus three AMI executives.

215. Remarks by Philip Birnbaum, George Washington University Medical Center Dean for Administrative Affairs, *reprinted in* THE INVESTOR-RELATED ACADEMIC HEALTH CENTER AND MEDICAN EDUCATION: AN UNCERTAIN COURTSHIP 53, 54-55 (1986).

216. *Id.* at 55; Interview with Philip Birnbaum in Washington, D.C. (Nov. 1985).

217. Michael Abramowitz, *GWU Hospital Ends Leasing Talks*, WASH. POST, Oct. 17, 1986, at F1 (attributing termination of talks to AMI's worsening financial problems and consequent loss of interest in leasing or buying the hospital).

218. See *supra* text accompanying note 25.

strengths of an investor-owned chain while retaining the authority to protect (or add) desired research and teaching programs, as well as related tertiary services. The AMI approach could provide access to research and teaching opportunities throughout an integrated, regional medical services system. Whenever cost considerations and academic aspirations conflict (as must occur often whether a hospital is investor-owned or not-for-profit), the joint governing board mechanism provides a forum for dialogue and compromise.

As of this writing, only Humana, the industry leader, is aggressively pursuing vertical integration.²¹⁹ Humana's acquisition of a major teaching center and its affiliated HMO in Chicago in October, 1990²²⁰ suggests that academic centers may play an important role in the company's campaign to develop prepaid health plans in new markets. But the place of teaching hospitals in Humana's growth program remains undefined. Governance arrangements for Humana's embryonic Chicago area network have not yet been worked out. Humana, generally considered the most centralized of the chains,²²¹ has not thus far embraced the AMI paradigm of academic centers as regional hubs with a central role in fashioning integrated service systems. In 1983, the Louisville-based company signed a long-term leasing agreement with the commonwealth of Kentucky to operate the University of Louisville School of Medicine's principle teaching affiliate, which the firm renamed "Humana Hospital—University." But until 1990, Humana did not consummate another leasing or purchase deal involving an academic center.²²²

Meanwhile, the company has pursued a parallel tertiary care track, unlinked to academic medicine. In 1982, Humana began its "Centers of Excellence" program, a systematic effort to develop a "network of regional referral and consultation centers" within company-owned hospitals not tied to medical schools.²²³ By early 1985, the firm had designated (by subspecialty) fourteen centers at twelve hospitals in eight states.²²⁴ Through August 1984, the tax-exempt "Humana Foundation" had channeled \$661,000 to these centers for so-called "clinical research

219. See *supra* text accompanying notes 199-201.

220. See *supra* note 37 and accompanying text.

221. Siegrist, *supra* note 130, at 45.

222. A 1984 agreement between Humana and the Chicago Medical School to build and operate a new teaching hospital was abandoned in 1988 after Humana failed to obtain the necessary regulatory approval. See *supra* note 379.

223. HUMANA, INC., CENTERS OF EXCELLENCE 2 (1985) (promotional pamphlet).

224. *Id.* at 7 (three for cardiovascular disease, three for diabetes, and one each for burns, pulmonary disease, spinal injuries, complicated neurological problems, orthopedics, ophthalmology, and obstetrics and gynecology).

and medical education,"²²⁵ including trials of potentially income-producing treatments and training programs for community physicians and allied professionals.

At the University of Louisville School of Medicine, "Centers of Excellence" and other Humana research and referral programs have aroused concern. Dean Donald Kmetz, chief of staff at Humana Hospital—University, complained publicly about Humana's decision to base its high-profile artificial heart program²²⁶ at another Humana hospital in the Louisville area.²²⁷ Nuclear Magnetic Resonance Imaging (MRI) and additional sophisticated, tertiary care technologies were also first awarded to other area facilities instead of to Humana Hospital—University. Instead of "a great networking of Humana hospital services" in Louisville, with the company-run teaching hospital as the referral hub, there has been fierce competition between Humana's facilities in the region.²²⁸ For the University of Louisville, ambivalence at corporate headquarters about whether to rely wholly on academic centers for tertiary services or to develop tertiary capacities at non-teaching facilities has meant fewer resources and a less diverse patient base for teaching and research. Other academic institutions contemplating alliances with Humana would do well to bargain vigorously for governance structures similar to the one proposed by AMI during its talks with George Washington.

V. THRESHOLD OBJECTIONS: MORALITY AND ECONOMICS

At fiscally troubled academic centers around the nation, the potential economic benefits of alliance with the investor-owned health services sector have generated interest among trustees and administrators. But a strong current of opinion within academic medicine holds that such alliances ought to be avoided. Adherents to this view assert that the very presence of for-profit enterprise in health care is so objectionable in principle that medical academia ought to eschew involvement with it. Even

225. *Id.* at 37.

226. *See supra* note 188.

227. Donald R. Kmetz, *The Investor-Owned Hospital in an Academic Medical Center*, in *THE INVESTOR-RELATED ACADEMIC HEALTH CENTER AND MEDICAL EDUCATION: AN UNCERTAIN COURTSHIP* 172, 178-79 (1986). The implant program was given to Humana Hospital—Audubon's "Humana Heart Institute International," one of the company's designated "Centers of Excellence." *Id.*

228. *Id.*

if investor-owned hospital chains must be tolerated as a distasteful inevitability, these critics contend, chain ownership or lessorship of a teaching hospital (1) sets an undesirable example and (2) poses intolerable dangers for the hospital's academic missions.

Though often passionately stated, these threshold objections tend to be incompletely articulated. The reasoning behind them is often fragmentary. Opponents of any role for investor-owned enterprise in academic medicine express a mixture of moral, economic, and other concerns. I will examine these concerns by reconstructing and assessing the premises and reasoning behind them.

A. MEDICAL CARE AS A RIGHT

Those opposed in principle to the delivery of hospital services by investor-owned firms must at the outset face an obvious problem—the great bulk of our goods and services are provided for a profit without provoking widespread outrage in our society. Thus, if their argument is to remain within the moral mainstream of a capitalist culture,²²⁹ it must start with the proposition that what hospitals do is somehow different—so different that the profit motive in conjunction with market mechanisms is incapable of generating and distributing hospital services in a manner tolerable to our communal values.²³⁰ However, some state this proposition as though it were self-evident. Satisfied with their own insistence that medical care is vital for health and therefore a right, morally²³¹ if not legally,²³² they declare without explanation that its sale for a

229. It need not, of course; some who oppose the sale of health services for a profit do so because they reject the capitalist approach to distribution of goods and services more generally. Their objections do not specifically target medical services and thus lie beyond the framework of my analysis here.

230. For a discussion of the importance of medical resource allocation decisions to the evolution of our communal life, and of the consequent hazards of making medical allocative choices that break with cherished (even if mythic) moral norms, see Richard A. Burt, *The Ideal of Community in the Work of the President's Commission*, 6 CARDOZO L. REV. 267 (1984).

231. The idea of a right to medical care, deducible from a right to health, won wide cultural acceptance in the 1970s. See STARR, *supra* note 42, at 389. But in the 1980s the language of rights played a diminished role in advocacy efforts by scholarly commentators and political leaders committed to making medical services universally available. In 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded that society has an "ethical obligation" to ensure all citizens of access to "an adequate level of care without excessive burdens." In doing so, the commission explicitly eschewed the concept of a "right":

Discussions of a right to health care have frequently been premised on offering patients access to all beneficial care, to all care that others are receiving, or to all that they need—or want. By creating impossible demands on society's resources for health care, such formulations have risked negating the entire notion of a moral obligation to secure care for those who lack it.

profit is repugnant to our values.²³³ But an explanation is essential in our social context, because other goods that are equally vital—including food, clothing, and shelter—are provided for a profit, via market mechanisms, without arousing widespread moral indignation.²³⁴

The commission also concluded that society's "ethical obligation" to ensure access to care is "balanced" by "individual obligations" to pay a "fair share" of one's medical costs and to reduce health risks. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 1-6 (1983) [hereinafter PRESIDENT'S COMMISSION].

The Commission's (and others') avoidance of rights language has been sharply criticized by right-to-health care advocates. See, e.g., John D. Arras, *Retreat from the Right to Health Care: The President's Commission and Access to Health Care*, 6 CARDOZO L. REV. 321 (1984); Ronald Bayer, *Ethics, Politics, and Access to Health Care: A Critical Analysis of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research*, 6 CARDOZO L. REV. 303 (1984). But the Commission's approach is consistent with emerging notions of communal obligation as the basis for public provision of services to the needy. See MICHAEL WALZER, SPHERES OF JUSTICES 64-94 (1983); Joel Handler, *Dependent People, the State, and the Modern/Postmodern Search for Dialogic Community*, 35 UCLA L. REV. 999 (1988).

232. American courts have not recognized a right to health care, *Harris v. McRae*, 448 U.S. 297, 317-318 (1980) (stating that the U.S. Constitution confers no entitlement to government-supported medical services), except in the case of statutory entitlements such as Medicaid, and for involuntarily confined persons. See, e.g., *Estelle v. Gamble*, 429 U.S. 97 (1976) (holding that the Eighth Amendment proscription of cruel and unusual punishment requires that prisoners be given medical care); *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974) (The Due Process Clause of Fourteenth Amendment confers right to treatment upon psychiatric patients hospitalized against their will.).

Attempts to establish a common law right to emergency treatment in some circumstances, by creating exceptions to the tort principle that an actor has no duty to rescue others in distress, have met with limited success. See GEORGE J. ANNAS ET AL., *AMERICAN HEALTH LAW* 57-63 (1990). Moreover, some judges have said that government administrative action touching upon health and medicine may merit especially close scrutiny for procedural fairness and analytic thoroughness because health interests have "always had a special claim to judicial protection," *Environmental Defense Fund v. Ruckelshaus*, 439 F.2d 584, 598 (D.C. Cir. 1971) (Bazelon, C.J.) (not explicitly invoking the Due Process Clause), but no court has employed this argument to constrain government action in the health care delivery sphere.

233. Even if medical care is a right, it hardly follows that the sale of medical services, whether for a profit or for compensation not conceptualized as including a profit, is contrary to our values. The claim that one ought to have a right to receive health services (even if one cannot pay for them) can be satisfied through public subsidies that enable anyone in need to purchase care.

234. Margaret Jane Radin has made the most comprehensive recent attempt to articulate a way of distinguishing between goods that should and should not be exchangeable for money (not quite the same as distinguishing between things that should and should not be sold *for a profit*). See Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849 (1987). Rejecting market-failure analysis of restrictions on the alienation of goods and services, Radin argues that our beliefs about what should and should not be alienable (completely or with some restraints) are tied to our sense of these things' importance to the "personhood" of the potential seller. *Id.* at 1903. Goods that are central to the prospective seller's personhood according to an ideal "conception of human flourishing" should be inalienable, although certain "nonideal circumstances" may justify limited alienability. *Id.* at 1904. Radin's examples of such goods include sexuality and the bearing of children. By this measure, the alienability of virtually all health services should not be objectionable.

Government and private entities, it is true, provide subsidies or otherwise modify market mechanisms in order to enable poor individuals to purchase some minimum amount of these vital goods. Such modifications reduce to a socially tolerable level the negative moral externalities generated by the distribution of vital goods via the marketplace to consumers with unequal wealth.²³⁵ The fact that market modifications can make the provision of many vital goods for a profit tolerable illustrates the need for opponents of the for-profit hospital chains to distinguish hospital services from other vital goods in order to make a coherent case against the chains.

B. ARNOLD RELMAN'S CRITIQUE

More sophisticated critics of the chains attempt to make such a distinction. Within the academic medical community, Arnold Relman, until recently the editor of the *New England Journal of Medicine*, has emerged as the most active and prominent foe of investor-owned care. I will therefore focus most closely on Relman's critique, both because of its influence and because it represents the most serious attempt to articulate a rational basis for opposition to the for-profit form in health care.²³⁶ Relman does not challenge the legitimacy of for-profit enterprise for the supply of most goods and services.²³⁷ He finds "nothing particularly worrisome" about the provision of pharmaceuticals and medical equipment for a profit,²³⁸ though surely they play a vital role in the delivery of clinical care. But he contends that there is a critical distinction between

235. These external costs—the affront to our respect for the lives of individuals regardless of their lot—may be separated into two categories: (1) the "costs of costing" (the insult to our respect for life which results from an explicit assignment of a dollar value to "some precious activity integral to life") and (2) the insult to egalitarian values which results from the differential availability of a "precious activity integral to life" among purchasers with unequal distributions of wealth. GUIDO CALABRESI & PHILLIP BOBBITT, *TRAGIC CHOICES* 32-34 (1978). These negative externalities are incidental to market distribution of such "precious activity" by either for-profit or non-profit suppliers. But they are greatly magnified in the for-profit setting by the contrast between a purchaser's vital dependence on the "precious activity" and the presence of a class of individuals—investors—frankly motivated to exploit this vulnerability for maximum personal gain.

236. Another reason for focusing on Relman's critique is that his intuitions are widely shared in the medical profession. No other author, in my judgment, has so eloquently captured physicians' anxiety about the emergence of large, investor-owned hospital corporations. My emphasis on Relman's work represents an acknowledgment of his singular success in articulating the unstated concerns of many physicians.

237. American College of Physicians, *The Medical-Industrial Complex*, URBAN HEALTH, July 1984, at 30, 51 (debate between Arnold S. Relman and National Medical Enterprises President John Bedrosian) [hereinafter Relman-Bedrosian Debate].

238. Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963 (1980).

the supply of drugs or equipment and the provision of medical *services* by investor-owned enterprise.²³⁹

In support of this claimed distinction, Relman repeats the refrain, unhelpful to his case for the reasons just discussed, that health care is "a basic right of all citizens."²⁴⁰ But he then proceeds to make several additional arguments in support of the distinction: (1) health services are a "public good" and thus cannot be left to the marketplace; (2) consumers, when they become patients, demand medical care "virtually without concern for price," rendering "the classic laws of supply and demand" inoperative; and (3) patients' dependence upon their physicians' judgment renders them unacceptably vulnerable to abuse by for-profit health care providers.²⁴¹ As a basis for objecting to the entry of for-profit entities into the market for hospital services, each of these arguments collapses on close inspection.

1. *Medical Care as a Public Good*

Relman's claim that medical services are a public good and therefore should not be left to market mechanisms is an apparent allusion to the conventional welfare economics principle that private firms under competitive conditions tend to supply public goods in quantities below socially optimal levels. The normative implication of this principle is that government—along with private, not-for-profit providers²⁴²—ought to step into the breach and provide public goods at optimal levels. Because for-profit firms, driven by market incentives, will inevitably undersupply public goods, conversion of a hospital from nonprofit to for-profit status will lead to the shutdown of services necessary for optimality, according to Relman.²⁴³

However, Relman's allusion to the welfare economics concept of public good misapprehends its meaning. A service or commodity is a public good in the economic sense to the extent that its consumption by any one actor does not reduce the quantity available to others in a given

239. *Id.*

240. *Id.* at 966.

241. *Id.* at 966-67.

242. See BURTON A. WEISBROD, *THE VOLUNTARY NONPROFIT SECTOR* (1977) (contending that the primary economic role of nonprofit organizations is to fill gaps in government provision of public goods).

243. Relman does not explicitly state this; he merely declares that health care "is a public rather than a private good" and claims that public subsidies for medical care are "in recognition of this fact." Relman, *supra* note 238, at 966. This fragment of reasoning, though, makes little sense except as an allusion to the welfare economics theory of public goods in support of his claim that for-profit hospitals will fail to provide many socially needed services.

community. In other words, a good is "public" to the degree that providing it for any one consumer makes the good available to all without additional cost.²⁴⁴ Some theorists also impose the condition that provision of the good to any one consumer is not possible without supplying it to others—that is, nonpaying consumers cannot be excluded.²⁴⁵ Although other analysts allow the possibility of excluding nonpaying consumers, they point out that there are costs involved in excluding nonpayers and determining prices that will achieve optimal provision of the good.²⁴⁶ Either way, commercial firms will lack sufficient incentive to provide public goods in quantities that maximize social welfare.

Classic examples of public goods include lighthouses, radio broadcasts, and clean air. Biomedical research results are also a public good when reported in accessible journals. However, medical care is not a public good. Provision of clinical care to one patient does not make that care available to others without additional cost. For any given level of aggregate medical services expenditure, caring for one patient reduces the services available to others. Moreover, exclusion of nonpaying patients poses little administrative difficulty.²⁴⁷ Thus, conventional public goods analysis does not support the prediction that for-profit firms will supply hospital services at a level below the social optimum, given an acceptance of the current distribution of wealth and of consumers' marginal rates of substitution for medical care relative to other goods.

Yet a variant of the public goods concept has great relevance for the welfare economics of medical care. Consumption of any private good evokes emotional responses among members of the consumer's community. Though not readily quantifiable in dollar terms and rarely the subject of economic analysis, these responses can be conceptualized as

244. See JACK HIRSHLEIFER, *PRICE THEORY AND APPLICATIONS* 539 (2d ed. 1980).

245. See, e.g., RICHARD A. MUSGRAVE & PEGGY B. MUSGRAVE, *PUBLIC FINANCE IN THEORY AND PRACTICE* 49-80 (2d ed. 1976).

246. See, e.g., HIRSHLEIFER, *supra* note 244, at 541-43. The expense of excluding free riders may for some goods involve a calculable package of transaction costs (e.g., for television broadcasts, the expense of developing and administering a system for scrambling signals), while for other goods it may be incalculable (e.g., for scientific research, the affront to free speech values and the inhibition of future progress that would result from restrictions on publication), or even inconceivable (e.g., in the case of clean air).

The cost of setting optimal prices is primarily that of monitoring consumers' marginal rates of substitution in consumption, since optimal provision of the good requires price discrimination in accordance with these marginal rates. *Id.* at 541-42.

247. The moral cost of excluding nonpayers—the affront to our respect for human life, dignity and equality—is another matter.

externalities, and they can significantly affect social welfare. These externalities may be negative for consumption of certain goods by certain consumers—for example, purchase of a Mercedes Benz by a twenty-five-year-old investment banker—or positive, as when a critically ill twenty-five-year-old obtains lifesaving medical care. Complex interplays occur between conflicting feelings, such as envy and empathy, which are rooted in cultural norms and individual character.

More than for almost any other good in our secular culture, the net emotional externality generated by medical care is strongly positive. Our belief that others are receiving needed care gratifies our empathic needs and fulfills our respect for human life and dignity. In this sense, medical care has a public-good dimension.²⁴⁸ Provision of needed care to any one patient contributes to the welfare of others at no additional cost. Exclusion of nonpayers from this utility gain is impossible.

If all consumers were willing and able to buy the amount of health care that society perceives as needed, market mechanisms would be adequate to satisfy, to a close approximation, consumers' aggregate desire to believe that everyone receives needed care.²⁴⁹ But pure market mechanisms cannot provide all the care needed (according to social consensus) by consumers unable or unwilling to purchase it.²⁵⁰ Thus, the market, unaided, will undersupply (relative to the social optimum) the public-good or positive-externality aspect of medical care—the gratification derived from the belief that all in the community are receiving needed care.

Whether organized as for-profit or nonprofit corporations, hospitals driven by market forces will therefore tend to undersupply clinical services relative to the social optimum as defined by citizens' subjective sense of their needs.²⁵¹ Biomedical research, more classically a public good,

248. Public goods are a species of beneficial externality. HIRSHLEIFER, *supra* note 244, at 539.

249. In theory, medical services would still be undersupplied, because market mechanisms provide no opportunity to mediate the positive emotional externality aspect of medical care. But this undersupply should not be particularly large, because (1) marginal preferences for medical care (relative to other commodities), in both its private and public good aspects, ought to drop precipitously to zero for care in excess of each individual's sensed need, and (2) demand for medical care at levels beneath consumers' sensed need is likely to be relatively inelastic.

250. American political institutions periodically restate this consensus (although they have yet to fully implement it) by insisting that society has an obligation to provide medical care to all who need it. See, e.g., Pepper Commission, *supra* note 183; PRESIDENT'S COMMISSION, *supra* note 231.

251. This characterization is so even though market-driven institutions may *oversupply* clinical services, judged by the criterion of substantial biological efficacy, because consumers (or their physician purchasing agents) *perceive* a need for some clinical services that may actually possess only minimal biological efficacy.

will also be performed by purely market-driven institutions at socially suboptimal levels.²⁵²

But this is hardly a convincing rationale for objecting to the entry of investor-owned institutions into the market for medical care or research. The optimality gap can be filled by government action abetted by private philanthropy. That action can take several forms, including (1) direct provision of care or performance of research by government or philanthropic institutions;²⁵³ (2) government or philanthropic subsidies for private sector health care and research institutions;²⁵⁴ and (3) government or philanthropic subsidies for purchasers of clinical services from private sector providers.²⁵⁵ Investor-owned institutions, meanwhile, can continue to operate, enabling society to take advantage of their efficiencies while public policy and private philanthropy correct for the market failures discussed above.

Relman accurately observes that investor-owned hospital chains exploit government action—in particular, publicly-funded medical research and development—for their own gain.²⁵⁶ Without explanation, he takes umbrage at this fact, as though there is some essential immorality in selling hospital services for a profit. But investor-owned firms in a vast range of industries benefit in one way or another from government spending. Air carriers take advantage of government support for airports and traffic control; farmers receive huge federal subsidies; and defense contractors exploit federal research and development outlays. The activist liberal state subsidizes not only public goods but myriad private goods employed as factors of production by for-profit firms. Investor-owned pharmaceutical and medical equipment companies, about which Relman finds “nothing particularly worrisome,”²⁵⁷ rely heavily upon publicly funded research in developing and promoting new products.²⁵⁸ Relman’s objection to the for-profit hospital chains’ similar reliance on government-sponsored research is out of synchrony with the

252. Relman makes this point, albeit selectively for investor-owned institutions. Relman, *supra* note 238, at 966-67. Economists would not dispute him, though the point is applicable to all market-driven institutions, whatever their legal form.

253. Municipally-owned hospitals for the indigent and the NIH intramural research program are examples.

254. The Hill-Burton grant program for community hospital construction and NIH grants to researchers at private institutions are examples.

255. Medicare and Medicaid are the outstanding examples.

256. Relman-Bedrosian Debate, *supra* note 237, at 34 (Relman’s comments).

257. Relman, *supra* note 238, at 963.

258. Indeed, because investor-owned hospitals benefit from publicly-sponsored research which is generally garnered by use of technologies purchased from pharmaceutical and medical equipment providers. The pharmaceutical and equipment firms’ exploitation of such research is more direct.

realities of the modern, activist state and inconsistent with his toleration of public spending for other capitalist enterprise.

2. *The Price-Auction Model and Consumer Insensitivity to Cost*

Relman contends that because patients demand medical care “virtually without concern for price,” the “classic laws of supply and demand” do not operate in the health care market. Consumers of clinical services, Relman notes, tend to be quite insensitive to cost. Even when paying their own way, without insurance, worried patients facing hard choices about their care are likely to deviate from the classic price-auction model of the perfectly prudent, discriminating consumer. When insurance enters the picture, in either the cost-based or prospective payment form, consumers’ cost-discriminating inclinations diminish further; they recede to the vanishing point when all expenses are covered.²⁵⁹ Thus, says Relman, reliance on profit-seeking firms for the provision of hospital services is fraught with “obvious . . . possibilities for abuse and for distortion of social purposes.”²⁶⁰

a. *Imperfect cost discrimination:* Though fragmentary in form, this critique of the classic price-auction model in the medical care context is on target. Faced with the threat of illness, a rational, self-paying consumer must balance the benefits of seeking an optimal price-quality trade-off position against the costs of “shopping around”—for example, real and feared dangers that an illness may progress and psychic discomfort from prolonging critical decisions. Such a balancing process may result in some heuristically planned cost-saving efforts.²⁶¹ But unless competing providers of care can make market information so readily available to patients (or their purchasing agents) that their cost of gathering it is negligible, patients will discriminate imperfectly in their medical care consumption choices. They will thus be vulnerable to financial exploitation by providers.

Imperfect cost discrimination is encouraged by insurance. Insurance shifts the financial cost of imperfect discrimination from each individual patient to the group covered by a given plan. Within a covered group, in other words, insurance *externalizes* the negative *internalities*

259. See Relman, *supra* note 238, at 966.

260. *Id.* at 967.

261. Cf. LESTER C. THUROW, DANGEROUS CURRENTS: THE STATE OF ECONOMICS 226 (1983) (A “realistic model of ‘rational’ choice will take into account a strategic view of the world where there is not enough time to maximize on every margin.”).

created by each insured's imperfect cost discrimination in the consumption of medical care.²⁶² The result, assuming an insurance plan with so many subscribers that externalization of the loss from each consumer's imperfect discrimination virtually eliminates *individual* loss,²⁶³ is that a patient's incentive to discriminate with respect to cost diminishes in inverse proportion to his or her coverage.²⁶⁴

Thus, the disciplinary power of consumers' cost discrimination is sharply attenuated in the medical care market. The resulting potential for exploitation means that the market will not necessarily maximize welfare.²⁶⁵

b. *Unstable consumer preferences:* Relman's observation that patients facing the threat of illness are disinclined to shop for the best price points toward another more basic problem with applying the price-auction model of welfare maximization to medical care.²⁶⁶ The price-auction model presumes that each individual possesses a set of stable and exogenous preferences²⁶⁷ that determine consumption and production decisions. Whatever the virtues of this simplifying assumption in other economic settings,²⁶⁸ it is at sharp variance with consumers' actual

262. This is more frequently referred to as the "moral hazard" of insurance, a term I have avoided because of its normative tone.

263. That is, externalization of an individual's loss does not lead to a significant rise in that individual's insurance premium or health plan prepayment.

264. This is so for HMO-type plans as well as for conventional cost- and charge-based insurance. Cost savings in HMO-type plans are achieved not by changing the incentives of sick patients but by influencing providers' incentives and thus their clinical decisions and advice.

265. Arguably, medical care consumers who discriminate imperfectly with respect to cost could still maximize welfare if only the system could be corrected for insurance's "externalizing of externalities." Imperfect cost discrimination might be viewed as the product of rational, utility-maximizing consumers' attempts to balance the advantages of a thorough search for the best deal against the costs of such a search (for example, sustained fear and other psychic discomfort, the real risk that a disease may progress, and lost opportunities). But even the most rationally-minded consumer cannot meaningfully weigh unknown costs and benefits. And a consumer cannot know the value of forgone benefits—or costs—from alternatives he or she has not explored. These information imperfections render implausible the notion that price-auction mechanisms maximize welfare in this setting. Moreover, health care providers concerned about generating income might be expected to be aware of consumers' imperfect cost discrimination and to set prices accordingly higher.

The problem of imperfect cost discrimination is greatly compounded by the typical patient's uncertainty about the outcome of particular clinical services in his or her case and his or her inability, as a non-expert in a highly technical field, to competently assess the probabilities. See *infra* text accompanying notes 279-81.

266. Relman does not explicitly raise the problem considered here.

267. THUROW, *supra* note 261, at 22, 115. The model assumes, in other words, that life experience (including illness) does not influence preferences.

268. However attractive mathematically, the assumption is at wide variance with reality. See *id.* at 115, 176, 219-20, 222-26 (Preferences are shaped by social context and continually change with

health care market behavior. Faced with the imminent threat of dread disease, patients seem willing to spend vast resources to achieve slight marginal decreases in probabilistic morbidity. In the absence of such a threat, consumers' relative preferences (or marginal rates of substitution in consumption) for the same marginal reduction in morbidity tend to be much lower.²⁶⁹ This tendency is evinced by consumers' unwillingness to make relatively minor lifestyle changes that can lead to large reductions in probabilistic morbidity. Given this quirk of human nature, it is not axiomatic that an unfettered market economy for clinical services will maximize welfare. Indeed, the state might achieve a much greater welfare gain by acting to change lifestyle preferences and thereby inexpensively effect major reductions in morbidity not attainable solely through deference to the clinical marketplace.

c. *The price-auction model's flaws and the nonprofit/for-profit distinction:* When applied to health services, the competitive market is conceptually problematic as a model for optimizing well-being. Its flaws raise serious doubts about the simple competitive ideal that has animated some recent legislative proposals for health care reform,²⁷⁰ and about the increasingly competitive character of the medical care industry even without such reform.²⁷¹ For Relman and other critics, investor-owned hospital chains have become the prime focus of these doubts.²⁷² In contrast, these critics have looked approvingly upon the income-seeking behavior of nonprofit hospitals and even investor-owned pharmaceutical and medical equipment providers.²⁷³ The basis for such a distinction is hardly compelling.

ongoing economic and social activity; advertisers, psychiatrists, and others consume prodigious resources in attempts to change preferences.).

269. One might also describe this tendency as a reflection of risk aversion.

270. See Eli Ginzberg, *Procompetition in Health Care: Policy or Fantasy?*, 60 MILBANK MEMORIAL FUND Q. 386 (1982) (critiquing the market model and procompetitive health care reform proposals). But see Alain C. Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990s*, 320 NEW ENG. J. MED. 29 (1989); Alain C. Enthoven, *The Competition Strategy: Status and Prospects*, 304 NEW ENG. J. MED. 109 (1981) (discussing market-oriented reform proposals and offering a more sophisticated procompetitive approach featuring selective regulation and subsidies designed to compensate for market imperfections).

271. See *supra* text accompanying notes 91-112.

272. See, e.g., Leon Eisenberg, *The Case Against For-Profit Hospitals*, 35 HOSP. & COMMUNITY PSYCHIATRY 1009 (1984).

273. See, e.g., Relman-Bedrosian Debate, *supra* note 237, at 32-33 (Relman attempts to distinguish between the income-seeking behavior of for-profit and voluntary hospitals on the ground that only the voluntaries exist to serve "needs."). Relman finds for-profit drug and medical equipment companies acceptable because "there are no practical alternatives" to private production of these products. Relman, *supra* note 238, at 963.

A few sociologic studies indicate organizational differences between investor-owned and nonprofit hospitals that may reflect a greater commitment by the former to generating income.²⁷⁴ In addition, one careful study of nonprofit entrepreneurship suggests that administrators drawn to nonprofit organizations tend to be motivated, to a greater degree than their for-profit counterparts, by a variety of nonpecuniary aspirations that in turn distinguish the behavior of nonprofit from for-profit enterprises.²⁷⁵ However, economic pressures on all hospitals are narrowing any gap between nonprofit and for-profit organizational behavior.

Even before Medicare, as Henry Hansmann notes, nonprofit hospitals had evolved from their nineteenth century status as charitable institutions—"sickhouses for the poor"—into primarily "commercial" institutions—providers of service to paying customers.²⁷⁶ No longer able to rely on donative support for more than a tiny fraction of their expenses,²⁷⁷ they were compelled to support themselves, like any other business, by selling a product. Under mounting pressure from payers to hold down costs, nonprofit hospital administrators today are increasingly

274. See, e.g., William A. Rushing, *Profit and Nonprofit Orientations and the Differentiations-Coordination Hypothesis for Organizations: A Study of Small General Hospitals*, 41 AM. SOC. REV. 676 (1976) (For-profit hospitals have higher correlation than do nonprofits between the complexity of their operations and the author's operationally defined measure of administrative activity; the author suggests that this reflects the for-profits' clearer "criteria for assessing operations"—the profit motive.).

275. DENNIS R. YOUNG, *IF NOT FOR PROFIT, FOR WHAT?* (1983) (arguing that entrepreneurs of different motivations and styles sort themselves out by industries and economic sectors in a way that matches the preferences of these entrepreneurs for wealth, power, intellectual or moral purposes with the opportunities for achieving these goals in different parts of the economy).

But cf. JOHN K. GALBRAITH, *THE NEW INDUSTRIAL STATE* 128-58, 166-78 (2d ed. 1972) (Large, for-profit organizations pursue a variety of goals other than profit maximization, including survival, autonomy, growth, and technical virtuosity; these goals reflect individual employees' pursuit of their own pecuniary and non-pecuniary objectives.).

276. Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 866-67 (1980). Hansmann separates nonprofit organizations into two groups: "donative" (who receive most of their income from grants or donations) and "commercial" (who receive the bulk of their income as compensation for services rendered). He subdivides each of these groups into "mutual" (controlled by patrons) and "entrepreneurial" (free from control by patrons, usually by virtue of a self-perpetuating board of directors) categories. *Id.* at 840-42. Within this conceptual scheme, hospitals have evolved from "donative, entrepreneurial" status into "commercial, entrepreneurial" entities. See also ROSEMARY STEVENS, *IN SICKNESS AND IN WEALTH* 17-51 (1989) (tracing the transformation of American nonprofit hospitals into organizations primarily supported by revenues from paying patients).

277. From 1962 to 1966, philanthropy accounted for only 2.4 percent of hospital revenues. *Id.* at 866 n.89 (citing statistics from the U.S. Dep't of Health, Education, and Welfare).

thinking and acting like corporate managers,²⁷⁸ sacrificing values traditionally associated with nonprofit health care.²⁷⁹ Whatever the differences in personal motivation between nonprofit and for-profit managers, competitive pressures appear to be forcing a convergence of institutional behavior. Relman's selective assault on the for-profit segment of the hospital industry is not a coherent response to the larger problem of welfare losses caused by the emergence of new, more competitive industry norms in the absence of government action to correct for major market imperfections.

3. *Market Discipline and the Patient's Dependence on Physician Judgment*

Relman asserts that patients are unacceptably vulnerable to abuse by for-profit health care providers because of their dependence upon physicians' judgment. He separates this claim from his argument that the market for health care does not conform to the classic price-auction model because consumers do not act as perfectly prudent, discriminating purchasers. But it is in fact a closely related claim. The patient is so dependent upon physician judgment because of an extreme informational inequality: superior technical knowledge makes the doctor much better able than the patient to understand and assess the risks and benefits of alternative diagnostic and therapeutic measures.²⁸⁰ This information

278. See, e.g., Rashi Fein, *What is Wrong with the Language of Medicine*, 306 NEW ENG. J. MED. 863 (1982) (sharply criticizing an emerging "bottom line" consciousness among health care managers); Irwin T. David, *Why Tax-Exempt Hospitals Need Profit*, HEALTHCARE FIN. MGMT., Sept. 1982, at 46 (urging nonprofit hospital administrators to aim for operating surpluses, as a substitute for philanthropy, in order to cover the cost of asset replacement); Ronald Copeland & Philip Jacobs, *Cost of Capital, Target Rate of Return, and Investment Decision Making*, 16 HEALTH SERVICES RES. 335, 340 (1981) (debating whether a nonprofit hospital's managers should evaluate investments in terms of possible benefits for society or merely in terms of potential cash flows to the institution).

279. David Hilfiker, *A Doctor's View of Modern Medicine*, N.Y. TIMES, Feb. 23, 1986, § 6 (Magazine), at 44 (noting the increasing avoidance of indigent care by nonprofit university and community hospitals). A variety of subterfuges are regularly used by nonprofit hospitals to avoid admitting patients who are unable to pay. One is the intake of insured or otherwise self-paying emergency patients through elective admission channels, bypassing sicker indigent patients waiting in the emergency room, in order to avoid the appearance of preferential treatment for those able to pay. Personal communications, on condition of anonymity (1986).

280. In economic language, the cost of acquiring state-of-the-art market information (that is, the physician's technical knowledge) is prohibitive for the patient. However, dependent patient behavior is occasionally beneficial: the temporary release of a sick person from the responsibilities of autonomous living may have a positive therapeutic effect. See TALCOTT PARSONS, *THE SOCIAL SYSTEM* 428-47 (1951) (discussing the "sick role" and its benefits and hazards).

deficit renders the patient unable to independently make the discriminating demand decisions essential for discipline in a truly competitive market.

Instead, the patient relies upon his or her physician as a virtual purchasing agent for more than seventy percent of his or her medical expenditures.²⁸¹ Relman invokes Kenneth Arrow's classic argument that traditional limits on physicians' self-aggrandizing behavior represent a welfare-optimizing adjustment for such heavy dependence.²⁸² Relman asserts that for-profit hospital care violates these limits, risking "distortion of social purposes."²⁸³ But this negative conclusion about for-profit hospitals does not follow logically from Arrow's argument about physicians. A brief review of Arrow's reasoning makes this plain.

a. *Kenneth Arrow: Physicians' altruistic norms and the economics of clinical uncertainty:* Arrow begins from the premise that consumer uncertainty about the efficacy of medical treatment is inevitable. He notes that entrepreneurs under competitive conditions theoretically could offer insurance against this uncertainty—that is, insurance against a failure to benefit from medical care.²⁸⁴ Such "ideal insurance" would optimize social welfare in the face of uncertainty. In the absence of "ideal insurance,"²⁸⁵ the patient "wants to have some guarantee that at least the physician is using his knowledge to the best advantage."²⁸⁶ The medical profession, Arrow contends, has responded to this preference by

281. Arnold S. Relman, *The Allocation of Medical Resources by Physicians*, 55 J. MED. EDUC. 99 (1980).

282. Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

283. Relman, *supra* note 238, at 966-67; cf. Ginzberg, *supra* note 270 (invoking Arrow's analysis as a basis for opposition to legislative proposals for procompetitive health care reform).

284. Such insurance might take the form of payment to the physician in accordance with the degree of benefit—that is, a transfer of the risk from the patient to his or her doctor—but the individual physician would surely be intensely averse to such risk-bearing. Risk-averse patients and doctors create room for entrepreneurship: insurance carriers could contract with either physicians or potential patients to pool individuals' risks of failure to benefit from medical care. Under such an "ideal insurance" program, Arrow notes, welfare would be optimized because "medical care will always be undertaken in any case in which the expected utility, taking account of the probabilities, exceeds the expected medical cost." The patient, in theory, would "have no concern with the informational inequality between himself and the physician, since he would only be paying by results . . . , and his utility position would . . . be thoroughly guaranteed." Arrow, *supra* note 282, at 964-65.

285. Arrow makes no attempt to explain the non-existence of insurance against failure to benefit from medical care. Presumably, the answer has much to do with the difficulty of reliably assessing benefit and of placing a dollar value upon it. Benefits from medical care—whether through recovery, relief of discomfort, or slowing of deterioration—are intensely subjective things, in contrast to the financial cost of delivering care.

286. *Id.* at 965.

proclaiming its adherence to a set of ethical precepts intended to invite patient trust and confidence.²⁸⁷ The common theme behind these precepts is avoidance of "the obvious stigmata of profit-maximizing."²⁸⁸ Physicians commit themselves to a concern for their customers' welfare rooted in a genuine "collectivity orientation" that differs from the typical business person's pursuit of self-interest.²⁸⁹ A doctor's advice is supposed to be divorced from his or her financial or other self-interest. Commitment to these values and obligations is "part of the commodity the physician sells."²⁹⁰

b. *The irrelevance of Arrow's reasoning for hospitals:* Arrow writes that the predominance of nonprofit over proprietary hospitals reflects the same departure from the profit motive. Yet he struggles unsatisfyingly with the difficulty of applying to hospitals his explanation for physicians' professed deviation from Adam Smith-type ideals. He points presciently to the potential of for-profit hospitals to arouse admitting physicians' "suspicion and antagonism."²⁹¹ But without explanation he stops short of invoking his own "collectivity orientation" model of physician behavior to explain this antagonism. Instead, he proposes this model's polar opposite. For-profit hospitals, he suggests, "will tend to control total

287. Though Arrow's argument is ahistoric, it has a historical parallel. During the years between the Civil War and the Great Depression, American medicine achieved huge gains in its "cultural authority"—and in its practitioners' economic status—by enforcing diagnostic and therapeutic consensus and by establishing strict limits on self-promoting behavior. STARR, *supra* note 42, at 79-144.

288. Arrow, *supra* note 282, at 965.

289. *Id.* at 949 (drawing upon Talcot Parsons's distinction between the business norm of self-interest and the "collectivity-orientation" of medicine and other professions).

290. *Id.* at 965. Arrow's interpretation here of physicians' altruistic professional norms as a response to consumer preferences—that is as market-driven behavior—is somewhat at odds with the general thrust of his argument. Elsewhere in the same article, he characterizes these norms and other "special structural characteristics of the medical care market" as *nonmarket* responses to the "optimality gap" created by "the nonmarketability of the bearing of suitable risks and the imperfect marketability of information." *Id.* at 947. Arrow contends that these nonmarket responses exemplify a general tendency for social institutions to pursue optimality through noncompetitive means when the market fails to insure against uncertainty. *Id.* at 967.

291. *Id.* at 950. He notes also that private and public subsidies (philanthropy, tax exemptions, and direct government support) decrease nonprofit hospitals' costs, *id.*, but this is not an *explanation* because it says nothing about *why* philanthropists or governments choose to aid nonprofits. Moreover, we have no empirical basis for believing that the *relatively* small cost reductions resulting from selective private and public subsidization of nonprofits make a decisive difference for patients or their admitting physicians. Indeed, the decreased sensitivity of sick patients to medical care cost differentials, *supra* text accompanying notes 261-65, would suggest otherwise.

costs to the patient [including physicians' fees] more closely."²⁹² Admitting physicians will therefore tend to select nonprofits in order to better protect their own incomes.²⁹³

Arrow leaves this contradiction unexplained. But Henry Hansmann, whose general theory of nonprofit enterprise is conceptually akin to Arrow's interpretation of doctors' altruistic ethic,²⁹⁴ points to the underlying problem. The reasons for physicians' altruistic ethic—which are, according to Arrow, the patient's vastly inferior technical knowledge, dependence on the doctor as a purchasing agent, and consequent preference for assurance that the doctor will act as a fiduciary—do not apply to the hospital.

When a patient enters the hospital, Hansmann notes, he or she remains under the care of a physician who is typically not a hospital employee. That physician is the patient's major economic nexus to the hospital. Acting as the patient's agent, the physician chooses among the hospital's technical services and monitors their quality.²⁹⁵ The physician's role in the purchase of inpatient diagnostic and therapeutic services is not different in principle from his or her role as a prescriber of medication. Technical knowledge enables the physician to perform this role in a discriminating manner that preserves the potential for market

292. *Id.* at 951 n.21.

293. *Id.* (crediting C. R. Rorem for this idea). This suggestion anticipated (by a decade) Pauly's and Redisch's mathematical model of the nonprofit hospital as an entity controlled by staff physicians and managed to maximize physicians' net incomes. Mark Pauly & Michael Redisch, *The Not-for-Profit Hospital as a Physicians' Cooperative*, 63 AM. ECON. REV. 87 (1973).

294. Hansmann argues essentially that nonprofit enterprise arises in response to "contract failure"—the inability of patrons, be they payers for commercial services or charity-minded donors, to ensure market discipline by controlling the use to which their contributions are put. The essential feature of nonprofit enterprise—a legal prohibition on the *distribution* of the enterprise's income except as reasonable compensation for services rendered or capital loaned—provides the patron with a protection that substitutes for market discipline. Contract failure may have a variety of causes, including patrons' lack of sufficient technical knowledge to evaluate goods or services adequately. In general, according to Hansmann, nonprofit enterprise will tend to arise where welfare losses from weakened market discipline outweigh the efficiency engendered by the profit incentive. Hansmann, *supra* note 276, at 837-45.

Hansmann observes that mechanisms other than the nonprofit form can constrain the distribution of an enterprise's income in excess of "reasonable" compensation for services or capital. Rate-of-return regulation and peer monitoring of professional behavior, for example, may provide analogous protection for consumers against contract failure. *Id.* at 869-70, 885. Arrow's model of physician commitment to a "collectivity orientation" and an altruistic ethic (expressed in part by physicians' self-imposed ethical obligation to charge "reasonable" fees) represents one such substitute for the nonprofit form.

295. Other physicians, typically employed by the hospital—such as diagnostic radiologists and surgical pathologists—provide some of these inpatient services. But in doing so, they function as technicians, acting at the behest of the admitting physician.

discipline.²⁹⁶ "Thus the consumer appears to be no more at the mercy of a for-profit hospital than he is at the mercy of a for-profit manufacturer of prescription drugs."²⁹⁷

Even if, as Relman presumes, for-profit hospitals are more avaricious than nonprofits, the physician acting as a fiduciary ought to be able to safeguard consumers from exploitation. Far from being a reason to fear abuse by for-profit hospitals, the patient's reliance on physician judgment is potentially the best protection against abuse by either for-profit or nonprofit providers of hospital services, pharmaceuticals, and other clinical needs.²⁹⁸ Relman's concern about patients' vulnerability to exploitation by the "medical-industrial complex" might be better channeled toward enhancing physicians' ability and determination to apply their technical knowledge critically, thereby fulfilling their fiduciary potential.²⁹⁹

296. Patients themselves are able to make discriminating judgments about the nontechnical aspects of hospital service—e.g., food, other hotel-like amenities, and the compassion and politeness of staff. Patients can communicate these judgments to their admitting physicians. Feelings about particular hospitals may even influence some patients' selection of an admitting physician. Informed patient choice thus plays some role in ensuring market discipline within the hospital industry.

297. Hansmann, *supra* note 276, at 866-67.

298. See Letter from Uwe Reinhardt to Arnold Relman (Oct. 16, 1984), reprinted in INSTITUTE OF MEDICINE, FOR-PROFIT ENTERPRISE IN HEALTH CARE 217, 218-19 (Bradford Gray ed., 1986) ("As long as physicians can keep their noses clean of economic conflicts of interest in their role as the patients' agents, they should be able to act as their patients' powerful ombudsmen in dealing with investor-owned institutions.").

299. Relman discusses the physician's fiduciary role as a force for market discipline, but his approach is constrained by his focus on for-profit enterprise as *the* culprit behind wasteful overuse of health services. He limits his concern to the conflict between physicians' fiduciary obligations and the lure of private enterprise. On this, he offers a radical proposal: the American Medical Association's Principles of Ethics ought to bar physicians from having any "pecuniary association" with for-profit health care enterprise. Relman would bar doctors from owning stock, receiving start-up subsidies for their practices, or otherwise deriving any financial gain from corporate enterprise in health care. "[P]racticing physicians," he asserts, "should derive no financial benefit from the health-care market except from their own professional services." Relman, *supra* note 238, at 967. Arguably, elimination of the most acute conflicts of interest might be achieved with a less far-reaching restriction. Physicians, for example, might merely be barred from referring patients to facilities (such as hospitals, nursing homes, clinical laboratories) in which they have an interest. But the problem addressed by Relman's proposal merits more attention.

Dismissed or left unaddressed by Relman are factors that may undermine physicians' effectiveness as fiduciaries irrespective of whether hospital services are provided by for-profit firms. Fee schedules that place much higher valuations on time spent performing procedures than on cognitive time (such as time spent taking patients' histories and analyzing their clinical problems) invite physicians to opt for procedures with doubtful marginal clinical utility. Steven A. Schroeder, *Medical Technology and Academic Medicine: The Doctor-Producers' Dilemma*, 56 J. MED. EDUC. 634, 636-37 (1981). The enormous potential for exploitation is suggested by studies showing that similarly trained physicians caring for similar patients in similar settings differ by up to twenty-fold in their use of some technologies without an obvious effect on quality of outcome. *Id.* at 637; see also *infra*

C. ALLEGATIONS OF "CREAM-SKIMMING" BY FOR-PROFIT HOSPITALS

1. *Cross-Subsidization and the Potential for Cream-Skimming*

Academic medical centers and other nonprofit hospitals have evolved complex pricing structures designed to provide support via cross-subsidization for a variety of activities. Hospitals sell some clinical services at prices much greater than cost³⁰⁰ in order to provide others at below cost,³⁰¹ or to support unreimbursed activities (for example, research, teaching, and indigent care). Different classes of consumers, moreover, are often charged at different rates for the same services, depending on their insurance coverage.³⁰²

Another implicit form of price discrimination is average-cost rate setting, under which patients who require varying intensities of care are placed within the same pricing category.³⁰³ In most hospitals, for example, patients with a wide range of illness severity, who place very different demands on the nursing staff, are charged at the same per diem rate for nursing and other basic services. Under average-cost pricing, less clinically needy patients subsidize sicker, more demanding patients.

text accompanying notes 354-60 (noting that pro-technology bias pervades reimbursement of both doctors and hospitals).

More insidiously, medical training and socialization may nurture a disinclination to critically and independently assess claims made by promoters in the health care marketplace. Clinicians-in-training are encouraged to learn by emulating charismatic senior doctors or by simply acceding to the mores of higher authority, in contrast to the emphasis on critical thinking more characteristic of advanced education in law, engineering, and academic fields. See Eric Marcus, *The Role of Liaison Psychiatry in the Clinical Training of Medical Students*, in CONSULTATION-LIAISON PSYCHIATRY: CURRENT TRENDS AND NEW PERSPECTIVES 267 (Jerry B. Finkel ed., 1983) (defending focus on uncritical obedience to authority in clinical training). This style of learning may prepare physicians well for pressured clinical situations in which decisiveness and obedience to a leader are critical for a good outcome. But it may be poor preparation for the exercise of independent, critical judgment amidst myriad promotional claims by drug and equipment manufacturers, hospitals, laboratories, and other service suppliers.

300. Typical examples include inpatient laboratory studies, operating room time, and diagnostic imaging. Hyman Joseph, *On Interdepartment Pricing of Not-For-Profit Hospitals*, Q. REV. ECON. & BUS., Spring 1976, at 33. In general, services sold at rates above cost tend to be (1) well-covered by insurance and (2) needed in situations (such as inpatient stays) that make shopping for a better price impractical.

301. Delivery room services are a typical example. *Id.* Services sold below cost tend to be (1) uncovered by health insurance and (2) purchased electively by consumers with ample opportunity to shop before buying.

302. For a discussion of price discrimination, see William D. White, *Regulating Competition in a Nonprofit Industry: The Problem of For-Profit Hospitals*, 16 INQUIRY 50, 52-54 (1979).

303. *Id.* at 54-55. In theory, services rendered to each patient could be individually monitored and billed for on a marginal cost basis, but in practice the difficulties of such comprehensive, individualized monitoring are prohibitive. *Id.*

These pricing strategies aim to maximize the revenue obtained from clinical services, given the constraints imposed by the hospital's patient care commitments—for example, a self-imposed obligation to serve certain patients who are unable to pay, or to accept patients regardless of the severity of their illnesses—and by available third-party and other payers. But these strategies create (in theory, at least) economic opportunities for hospitals that are unburdened by comparable patient care commitments or research and teaching programs.

Conceivably, an avaricious competitor could eliminate services that other hospitals price below cost, restrict admission of nonpaying and poorly insured patients, attempt to screen out the sickest (and most costly) patients,³⁰⁴ and curtail research and teaching activities. Having thereby reduced its losses on activities that are “unprofitable” under prevailing reimbursement schemes, it would be in position to “skim” away “profitable” patients³⁰⁵ by setting rates below those of its rivals, or by offering attractive frills such as more luxurious accommodations and dining services.

Critics of the for-profit hospital chains charge that they employ such cream-skimming strategies, dumping “unprofitable” patients on voluntary and government-owned facilities.³⁰⁶ By so doing, these critics argue, the for-profits undermine the system of cross-subsidization that enables nonprofit and publicly-owned facilities to meet their commitments to teaching, research, care for the medically indigent, and provision of costly services to the sickest patients.³⁰⁷ These critics call for government regulation to limit the growth of the for-profit sector,³⁰⁸ and they reject any ties between academic medicine and the for-profit chains on the ground that such relationships encourage the chains' growth by lending them a dangerous legitimacy. They warn, moreover, that if for-profit chains are permitted to buy or lease teaching hospitals, academic programs and care for the indigent at these hospitals will be directly threatened by cream-skimming patient selection practices.

304. For example, those patients likely to impose the heaviest demands and the highest marginal costs on nursing and other services included in the average cost-based per diem rate.

305. “Profitable” patients are those whose marginal cost to a hospital is less than what the facility can collect (from third party and other payers) for their care.

306. See, e.g., Leon Eisenberg, *The Case Against For-Profit Hospitals*, 35 HOSP. & COMMUNITY PSYCHIATRY 1009, 1011 (1984).

307. See, e.g., Letter from Arnold Relman to Uwe Reinhardt (Dec. 3, 1984), reprinted in INSTITUTE OF MEDICINE, FOR-PROFIT ENTERPRISE IN HEALTH CARE 220, 223 (Bradford Gray ed., 1986) (arguing that replacement of nonprofit hospitals by investor-owned facilities will diminish cross-subsidization of care for the poor).

308. White, *supra* note 302.

2. *Empirical Evidence*

Empirical research does not support the conclusion that for-profit hospitals engage in more cream-skimming than do nonprofits. The available data is insufficient for any ultimate conclusions about the extent of cream-skimming behavior in the for-profit and nonprofit sectors or the impact of skimming on the ability of teaching centers to support academic activities through cross-subsidization. But empirical studies of comparable for-profit and nonprofit community hospitals have not discerned significant differences in patient selection patterns.

One study compared clinical complexity and reimbursement sources for patients admitted to investor-owned and nonprofit hospitals matched on the basis of production costs, regulatory and reimbursement environments, medical practice patterns, population demographics, size, and services offered.³⁰⁹ This study found no significant difference in the clinical complexity of Medicare patients admitted to for-profits and nonprofits.³¹⁰ Nor did it discover significant differences in the ratios of inpatient days paid for by Medicare or Medicaid (which typically pay less than private insurers) to total inpatient days.³¹¹

This study did not examine the relative proportions of uncompensated (that is, charity and bad debt) care provided by for-profits and nonprofits. But another study, examining matched investor-owned and nonprofit community hospitals in California,³¹² found no significant

309. Watt et al., *supra* note 134 (examining the activity of eighty matched pairs of investor-owned chain and nonprofit community hospitals in eight states during 1978 and 1980).

310. To measure clinical complexity, the authors used the Medicare case-mix indices devised by the U.S. Health Care Financing Administration (HCFA) to assess inpatient costs for the purpose of calculating cost-based reimbursement schedules. Mean Medicare case-mix indices for the investor-owned and non-profit hospitals studied did not differ significantly. *Id.* at 90, 96.

311. *Id.* at 90.

312. Pattison & Katz, *supra* note 131. The authors analyzed data collected by the California Health Facilities Commission (CHFC), which divides California hospitals into twelve "peer groups" based on a number of factors, including size, location, teaching programs, and service-mix complexity. The authors compared for-profits and nonprofits within the two "peer groups" having the highest concentrations of investor-owned facilities. Excluded from these groups were major teaching and other tertiary care centers, rural and specialty hospitals, and health maintenance organization hospitals. *Id.* at 348. See also Frank Sloan & Robert Vracin, *Investor-Owned and Not-For-Profit Hospitals: Addressing Some Issues*, HEALTH AFF., Spring 1983, at 25 (reporting that matching for-profit and nonprofit hospitals did not differ significantly in their provision of uncompensated care as a percentage of total patient charges).

difference in uncompensated care.³¹³ This study also failed to find significant differences in treatment of Medicare and Medicaid patients.³¹⁴

These studies shed no light on whether for-profits are more prone than nonprofits to cut clinically needed services that are reimbursed for less than cost, or whether for-profits are more likely to spend less on research and teaching. The studies' method of comparing hospitals that were matched for various qualities—including services offered and the absence of research and teaching—precluded an attempt to answer these questions. But the studies do support the conclusion that for-profits are no more inclined than comparably-situated nonprofits to cream-skim by payer class or severity of illness.

The significance of comparisons between matching for-profit and nonprofit hospitals has been challenged by some critics of the for-profit sector. Such comparisons, they contend, mask large differences between the two sectors' commitments to providing free and below-cost care.³¹⁵ Comparison of matching hospitals, they argue, factors out variables—such as hospital size, location, and teaching status—relevant to an analysis of differences between the for-profit and nonprofit forms.³¹⁶ These critics point out that the investor-owned chains have in the past preferred to buy or build community (non-teaching) hospitals in areas with low populations of uninsured or poorly insured residents.

This is cream-skimming at a prior stage of corporate planning—decision making with respect to entry into new markets. Investor-owned hospitals appear unlikely to expand aggressively into impoverished areas, at least under our current system of health care financing. But cream-skimming at the market entry stage should not be conflated with cream-skimming at the stage of patient admitting. The comparable hospital studies suggest that *existing* for-profit hospitals are no more likely than matching nonprofits to engage in cream-skimming of the latter sort.³¹⁷ For-profit chains may be more likely than nonprofits to engage in cream-

313. *Id.* at 351. The investor-owned hospitals studied reported as zero their percentage of net patient revenues from charity, not significantly different from the nonprofits' minuscule 0.41 percent. The authors did not compare bad debt data. *Id.*

314. *Id.* at 350-51 (comparing for-profits' and nonprofits' percentages of net patient revenues from Medicare and Medicaid).

315. LEWIN & ASSOCIATES, SETTING THE RECORD STRAIGHT: THE PROVISION OF UNCOMPENSATED CARE BY NOT-FOR-PROFIT HOSPITALS § 2.14 (1988) (monograph commissioned by an association of nonprofit hospital trustees).

316. *Id.*

317. There is abundant evidence that both for-profit and nonprofit hospitals, including teaching centers, engage in large-scale cream-skimming (including the dumping of medically indigent patients in need of emergency care) at the expense of government-owned hospitals. *See, e.g.*, GENERAL

skimming of the *former* sort.³¹⁸ But this possibility is of dubious relevance to the question of whether a for-profit chain that has *already decided* to enter a market by acquiring a hospital can be expected to increase cream-skimming at the patient admitting stage. Evidence from studies of the patient selection behavior of comparable hospitals is much more pertinent to this question.

Thus, the claim that for-profit ownership or operation threatens the system of cross-subsidies that is so heavily relied upon by academic centers lacks a substantial basis. Price structures that permit cross-subsidization of indigent care and academic activities *are* under mounting pressure.³¹⁹ But that pressure is a product of the increasingly competitive nature of the hospital industry as a whole,³²⁰ not specifically the for-profit form.

3. *Cross-Subsidization and Democratic Values*

Even if the for-profit form itself endangered cross-subsidization, the threat would not justify opposition to either the growth of the investor-owned sector in general or its courtship of academic hospitals. However sacrosanct cross-subsidies have become in the eyes of teaching center administrators, the case for this method of financing medical research, teaching, and indigent care is hardly compelling. Cross-subsidies, Robert Clark has noted, are in essence taxes, imposed upon users of certain hospital services by private entities acting as "minigovernments."³²¹ The "tax rates" reflected in hospital pricing structures are largely the product of managers' revenue-maximizing strategies and are generally formulated without heed to democratic tax policy ideals of horizontal and vertical

ACCOUNTING OFFICE, NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION 21-24 (1990) (reporting that government-owned hospitals bore a highly disproportionate uncompensated care burden, relative to total hospital expenses, in four of five states studied); cf. HOUSE COMMITTEE ON GOVERNMENT OPERATIONS, EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING, H.R. REP. NO. 531, 100th Cong., 2d Sess. (1988) (reporting on widespread transfer of indigent emergency patients from private (nonprofit and for-profit) hospitals to government-owned facilities, in violation of federal law forbidding the transfer, for non-medical reasons, of patients in need of emergency care).

318. This proposition has not been empirically demonstrated. The market entry decisions of for-profit and nonprofit health care organizations in today's hospital care financing environment have not yet been subjected to comparative study.

319. See *supra* text accompanying notes 113-19.

320. See *supra* text accompanying notes 91-112.

321. Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416, 1468 (1980); see also P. FELDSTEIN, *HEALTH CARE ECONOMICS* 268-69 (1979) (objecting to cross-subsidization of some hospital activities with revenues from paying patients).

equity.³²² Even more troubling is the infringement upon the democratic process that cross-subsidies represent. On a billion dollar scale, an unelected elite of hospital managers and board members, representing a myriad of private organizations, is making legislative judgments—decisions about who must pay for the activities that cross-subsidies support. This phenomenon is without parallel in other sectors of American life. Clark goes so far as to propose that payers be given a statutory right to injunctive relief when a hospital provides a clinical service for a price less than that service's average variable cost.³²³

The strongest argument for cross-subsidies is that they are a necessary "second best" in the absence of adequate support from other sources for research, teaching, and care of the medically indigent.³²⁴ But sufficient support for these activities through more democratic means may be

322. Clark, *supra* note 321, at 1468. Cross-subsidization, Clark says, violates the principle of horizontal equity by selecting as taxpayers "those particular wealthy people who get sick and are hospitalized rather than . . . wealthy people in general." *Id.* (By the word "wealthy," Clark presumably means insured or self-paying.) Insurance attenuates this violation by spreading the cost of care to all policy owners. But insurers rarely cover one hundred percent of costs, and different groups of policy owners must pay drastically different insurance rates, based on actuarial estimates of risk. Defenders of cross-subsidization offer no ethical rationale for requiring the sickest patients (or those in the highest actuarial risk groups) to make the biggest contributions to the financing of research, teaching, and indigent care.

Clark writes that cross-subsidization achieves the vertical equity principle of progressivity (taxation in accordance with ability to pay) only in the crude sense that "those receiving the subsidy will tend to be poorer than those doing the subsidizing." *Id.* Some additional progressivity probably results from the tendency of more affluent people to buy more costly insurance policies that provide hospitals with more generous (e.g., charge-based) reimbursement. But the nexus between "taxation" and the purchase of services in a competitive environment severely limits hospitals' (and insurers') ability to "tax" at highly progressive rates. Moreover, insurance plans purchased by less affluent consumers often require higher co-payments, rendering cross-subsidies in some cases frankly regressive.

On the other hand, cross-subsidies occasionally compensate for serious horizontal and vertical inequities in insurance coverage. Expensive, nonelective clinical services poorly covered by insurance are sometimes priced below average cost and supported by surplus revenue from well-covered services and uninsured "frills" for the affluent (e.g., private rooms) priced above average cost. For patients in need of costly and poorly-insured services priced below average cost, cross-subsidies from better-insured services abet loss-spreading (compensating for horizontal inequity). Moreover, surpluses generated from frills and elective services well-covered only by affluent consumers' more beneficent insurance policies support more essential services for those less well off (reducing vertical inequity). See Jeffrey E. Harris, *Pricing Rules for Hospitals*, BELL J. ECON., Spring 1979, at 224 (presenting a mathematical model of hospital rate-setting strategy, concluding that goals of social welfare maximization and avoidance of financial losses are best achieved via price structures not tied to average costs).

323. Clark, *supra* note 321, at 1480-83 (urging that payers be given standing to sue hospitals for injunctions against provision of services for less than average variable cost). Clark makes average *variable* cost his criterion, instead of average *total* cost, because of the impracticality of allocating hospitals' large shared or fixed costs to particular clinical services. *Id.* at 1481.

324. See *id.* at 1470.

attainable if academic centers redirect their political efforts from defense of the cross-subsidy system to the development and implementation of alternatives.

In particular, a universal system of comprehensive national health insurance would eliminate the need to support some clinical services with surplus revenues from others.³²⁵ For teaching centers, universal health insurance holds the promise of a lasting solution to the problem of financing indigent and underinsured care. A national insurance scheme would free the financing of indigent care from vulnerability to the growing competitive pressure on hospital price structures. During the 1970s and 1980s, national health insurance foundered on concerns that it would fuel an even greater medical cost explosion.³²⁶ But a new generation of universal health insurance proposals that incorporate aggressive cost-control strategies³²⁷ could become the basis for progress toward enactment of a viable plan.

If all patients were adequately insured, providers could bill for each service category at its average cost without endangering any patient's ability to obtain essential services on a paying basis. Within each category, there would still be some implicit cross-subsidization. Some hospitalized patients need more care than others, and difficulties in monitoring render exact calculations of each patient's costs impossible.³²⁸ Analogously, within a prepaid plan's rate classes, some plan purchasers are poorer risks than others. But finely divided categories—such as Diagnosis Related Groups (DRGs) for hospitals and stratified actuarial groupings for HMOs—could minimize this variation. Distributional questions—issues of horizontal and vertical equity—could be dealt with

325. John Rafferty & Stuart O. Schweitzer, *Comparison of For-Profit and Nonprofit Hospitals: A Re-evaluation*, 11 INQUIRY 304, 308 (1974); cf. White, *supra* note 302, at 53-54 (arguing that comprehensive national health insurance would eliminate need for regulation to protect discriminatory pricing structures from potential cream-skimming because price discrimination is needed only when insurance is inadequate).

326. The failure of national health insurance during the late 1970s is a more complex story. Widespread fear of inflationary pressures, an impasse between the Carter Administration and Senator Edward Kennedy on the design of a plan, and the potency of opposing special interests combined to ensure a political stalemate despite intense and broad-based interest in the development of an insurance scheme. See STARR, *supra* note 42, at 411-17.

327. For example, "HealthAmerica" contains cost-control provisions that address the problems of unnecessary care and open-ended reimbursement fees. The proposal aims to reduce unnecessary care by establishing research programs to determine which care is necessary and then providing physicians with practice guidelines based on these findings. HealthAmerica would also encourage the development of private and public managed care programs aimed at steering patients toward the most efficient providers. The plan also calls for regulation of rate-setting negotiations between purchasers and providers to conform with national expenditure goals.

328. See *supra* text accompanying note 304.

through the political process (at the level of insurance policy design) rather than by individual hospitals and prepaid plans (at the rate-setting level).

Direct government support for biomedical research and teaching would likewise be more consonant with democratic values than is reliance on vast, hidden subsidies from government spending for clinical care.³²⁹ The incremental costs of clinical research and teaching are probably impossible to measure exactly, but reasonable estimates can be developed.³³⁰ Such estimates can form the basis for more informed public choices about spending levels for research and education. If private sector spending for research and teaching falls below the social optimum, as determined by the political process,³³¹ government can intervene with explicit subsidies to fill the gap. Instead of defending dubiously legitimate, hidden subsidies, academic medical leaders ought to make their case more openly through the political process.

D. OTHER OBJECTIONS

1. *Quality of Care*

Some opponents of entry by investor-owned hospital chains into the academic sector intimate that the for-profit form may jeopardize the quality of patient care.³³² Available evidence, though limited, lends little support to this fear. Several studies have compared staff physician qualifications, accreditation records, and outcome statistics at matched investor-owned and nonprofit hospitals. No significant differences were found

329. Enthoven, *supra* note 270, at 111 (criticizing subsidies for research and teaching hidden within Medicare and Medicaid reimbursement). The financing of research, teaching, and care for the uninsured through Medicare reimbursement, *supra* text accompanying notes 99-105, is regressive in comparison with financing of these activities from general tax revenues. Medicare reimbursement for inpatient services (Part A) is financed through the Social Security payroll tax, and approximately twenty-five percent of Medicare payments for outpatient services (Part B) comes from premiums paid by beneficiaries (the remainder comes from general tax revenues). HOUSE COMM. ON WAYS AND MEANS, 100TH CONG., 2D SESS., BACKGROUND MATERIAL ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS 136-42 (1988).

330. See *What Are Teaching Hospitals' Costs?*, *supra* note 113 (noting a federally-funded attempt by an accounting firm to assess the cost of research and teaching activities at academic medical centers).

331. There are, of course, multitudinous theoretical problems with the notion that our (or any) democratic process allocates resources in a socially optimal manner. AMARTYA K. SEN, COLLECTIVE CHOICE AND SOCIAL WELFARE (1970). But the allocative choices generated by democratic mechanisms are, in effect, operationally defined as optimal—or legitimate (subject to constitutional limitations)—by virtue of a society's commitment to the democratic process as its allocative method.

332. See, e.g., Arnold S. Relman, *Private Hospitals: Ethics and Profits*, BUS. & SOC'Y REV., Fall 1983, at 28 ("There is no objective evidence" that for-profits' services are "as good as" those provided by nonprofits.).

in these crude measures of quality.³³³ In 1986, an Institute of Medicine committee on for-profit health services conducted a comprehensive review of empirical studies comparing clinical outcomes, medical staff qualifications, nursing support, and physicians' assessments of quality at investor-owned and nonprofit hospitals.³³⁴ The panel concluded that available evidence "does not support the fear that for-profit health care is incompatible with quality of care."³³⁵ By most measures, the committee found, investor-owned hospitals are similar in quality to nonprofit facilities, and on some measures they are better.³³⁶

Although responsible critics of the chains do not dispute such evidence, these studies have done little to assuage the critics' concern about for-profit care's long-term quality implications.³³⁷ And, in a sense, their concern has a rational basis. Clinical quality, as traditionally defined, is under frontal assault in the newly competitive health care climate. As two critics of for-profit care point out, "[t]he judicial as well as the ethical imperative under which physicians function is that every possible diagnostic or therapeutic act that might benefit the patient must be begun and continued until or unless it is harmful or can be demonstrated to

333. Ermann & Gabel, *supra* note 135, at 59-60 (reviewing results from four empirical studies of quality at matched facilities). More recent studies have yielded equivocal results. A comparative study of mortality rates at for-profit and nonprofit hospitals, conducted after the Institute of Medicine issued its report, discerned a small but statistically significant difference in favor of the nonprofit facilities. Arthur Hartz, Henry Krakauer et al., *Hospital Characteristics and Mortality Rates*, 321 NEW ENG. J. MED. 1720 (1989). However, use of mortality data from individual hospitals (published annually by the Health Care Financing Administration since 1987) to compare hospitals' quality of care has been sharply criticized on the ground that hospital-specific mortality rates reflect myriad differences between hospitals' patient populations. E.g., Jesse Green, Leigh Passman, Neil Wintfeld, *Analyzing Hospital Mortality: The Consequences of Diversity in Patient Mix*, 265 JAMA 1849 (1991).

Another recent study, based on medical record reviews conducted by coordinated teams of physicians in New York State, discerned no significant differences in the incidence of medically induced injuries between hospitals of different ownership types. Troyen Brennan, Liesi Hebert et al., *Hospital Characteristics Associated with Adverse Events and Substandard Care*, 265 JAMA 3265 (1991). But this study found that the percentage of medically induced injuries caused by "negligence" (as judged by the medical record reviewing teams) was much lower in the three for-profit hospitals surveyed than in the entire sample (9.5 percent at the for-profits, compared to 24.9 percent for the overall sample, which was drawn from more than fifty hospitals). As the authors noted, the small number of for-profit facilities studied provides an insufficient basis for generalization about the relative incidence of medical negligence by ownership type.

334. COMM. ON IMPLICATIONS OF FOR-PROFIT ENTERPRISE IN HEALTH CARE, INSTITUTE OF MEDICINE, FOR-PROFIT ENTERPRISE IN HEALTH CARE 127-41 (1986).

335. *Id.* at 138.

336. *Id.* The committee also observed that hospitals owned by for-profit chains appear to be superior to the facilities they have largely replaced—free-standing for-profit hospitals. *Id.*

337. See, e.g., Donald O. Nutter, *Access to Care and the Evolution of Corporate, For-Profit Medicine*, 311 NEW ENG. J. MED. 917, 919 (1984).

have no effect."³³⁸ Under cost-plus and charge-based, no-questions-asked reimbursement, this ethic flourished. Physicians were free—even expected—to pursue “quality” as defined technically;³³⁹ they were unrestrained by spending limits that arise from conflicting claims on limited resources.³⁴⁰ But new competitive market conditions are forcing a redefinition of “quality.”

The traditional, technocratic ideal of quality is being challenged by alternative conceptions that reflect competing individual and social priorities.³⁴¹ The reality that scarcity mandates choices between medical care and other wants has emerged into public consciousness. Quality of care is being redefined to take greater account of how the recipients of care perceive its benefits relative to other paths toward well-being.³⁴² Through both market and political methods of allocation, individuals and society are openly choosing to limit medical spending, in favor of other preferences, despite the sacrifice of potential marginal gains in clinical outcome.³⁴³ This is a radical cultural change. Not surprisingly, it has stirred intensely negative feelings among those committed to an ideal of clinical quality that permits no compromise with competing priorities.³⁴⁴ For-profit hospital chains have become lightning rods for

338. Ernest Saward & Andrew Sorensen, *Competition, Profit, and the HMO*, 306 NEW ENG. J. MED. 929, 931 (1982).

339. The health economist Victor Fuchs has written of some physicians’ “monotechnic point of view,” insensitive to “the claims of competing wants or the divergence of [physicians’] priorities from those of other people,” and thus creating “a poor guide to social policy.” FUCHS, *supra* note 69, at 5.

340. When ethicists, in the 1960s and 1970s, challenged the medical imperative to do everything technically possible (and beneficial in a biological sense), their focus was typically on the suffering and indignity inflicted by heroic measures, not on the high cost of these measures, relative to the clinical gains attained.

341. Cf. Donald W. Light, *Is Competition Bad?*, 309 NEW ENG. J. MED. 1315, 1316 (1983) (breaking down quality into three dimensions: (1) technical and “clinical quality”—focused on by the medical profession; (2) “social quality—the overall quality of care relative to the health needs of a society”; and (3) “relative quality,” or cost-effectiveness).

342. “Competition,” Light writes, “introduces another kind of quality at the individual level that the professional model does not recognize—namely, quality as measured by consumer satisfaction.” *Id.* at 1317.

343. Purchase of prepaid comprehensive health plans, which provide care within a limited budget and must therefore sometimes opt against diagnostic and therapeutic measures with the potential to benefit a patient, is an example of a market method. The new Medicare system of prospective reimbursement by Diagnosis Related Groups (DRGs), which limits what government will spend to evaluate and treat a particular clinical problem, is one instance of a political method.

344. A bitter, highly publicized nationwide controversy ensued in 1984 when Colorado Governor Richard Lamm suggested that severely ill old people have a “duty to die” rather than consume high-cost medical care. *Governor Lamm Asserts Elderly, if Very Ill, Have “Duty to Die,”* N.Y. TIMES, Mar. 29, 1984, at A12; cf. DANIEL CALLAHAN, WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS (1990) (interpreting public perceptions of a health care delivery “crisis” as due in large

these feelings.³⁴⁵ The for-profit sector, though, cannot fairly be blamed for the new consciousness of scarcity that is transforming society's conception of clinical quality.

Nevertheless, prepaid and prospective payment schemes, which are now being fashioned in pursuit of a more cost/benefit-oriented ideal of quality, create new incentives for exploitation by for-profit and nonprofit institutions alike. Instead of profiting from doing more, providers can earn more by doing less. The danger exists that they will do less than what the buyers of services are paying for.³⁴⁶ They can do so, however, only with the active collaboration of the physicians responsible for writing orders. So long as physicians exercise genuinely independent judgment as their patients' purchasing agents, the kind of exploitation that is possible in theory cannot become reality.

To function adequately as fiduciaries for newly cost-conscious consumers, physicians will need to modify their technically biased conception of quality along the lines suggested above. But they can do so without relinquishing their role as independent judges of the merits of available technology. Academic physicians, in particular, can play a decisive part in this process by developing a data base on the benefits and risks of diagnostic and therapeutic procedures in varying clinical situations.³⁴⁷ The better the information available on the benefits and risks of alternative technologies, the more knowledgeably will physicians be able to compare the cost-effectiveness of differing clinical approaches to individual patients—and to construct distinctions between cost-effective

measure to Americans' insistence that all treatment of probable net benefit be provided and their reluctance to acknowledge the need to make social choices between beneficial medical treatment and other priorities).

345. By establishing prices, markets make society's allocations of resources among competing priorities explicit, thereby "brutally emphasiz[ing]" the reality that choices are being made and that no priority is "priceless." CALABRESI & BOBBIT, *supra* note 235, at 31-34. Thus, hostility to the denial of a good's "pricelessness" is likely to be directed at market mechanisms of allocation. (Markets may, of course, arouse antipathy for other reasons, such as their dependence on the existing distribution of wealth. *Id.* at 32.) As *avowedly* market-driven institutions, for-profit hospitals are high-profile targets for this hostility.

346. They could in theory reap a windfall by withholding diagnostic and therapeutic measures necessary to achieve the level of quality for which consumers are paying (measures with marginal probabilities of clinical benefit, relative to cost, lying above the cost-benefit threshold implicit in a given prospective payment plan).

347. Paul M. Ellwood, *Outcomes Management: A Technology of Patient Experience*, 318 NEW ENG. J. MED. 1549 (1988); Arnold S. Relman, *Assessment and Accountability: The Third Revolution in Medical Care*, 319 NEW ENG. J. MED. 1220 (1988). In 1989, Congress created a new Public Health Service entity, the Agency for Health Care Policy and Research (AHCPR), to organize and fund research into the effectiveness of medical technologies. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, tit. IX, 103 Stat. 2106.

clinical restraint and intemperate exploitation of the financial rewards of doing less.³⁴⁸

Other mechanisms offer additional protection against exploitative behavior. The news media's intense interest in medical matters makes exploitation a high-risk strategy, especially for investor-owned hospital chains concerned with establishing and protecting national brand names.³⁴⁹ The emerging tort doctrine of "corporate negligence," under which hospitals can be held liable for failing to prevent negligent treatment by staff physicians,³⁵⁰ is another reason for hospital managers to refrain from pressing doctors to deviate from established standards of cost-effective care.³⁵¹ Internal quality-control programs, designed to protect corporate reputation, and even disclosure of information in promotional campaigns—especially those targeted at knowledgeable mass-purchasers of care such as corporate medical directors—provide further consumer protection.

348. Clinical outcomes data alone, however, will not suffice to draw these distinctions. Uncertainty and conflict over definitions of effectiveness (sometimes resulting in conflicting research findings regarding effectiveness), varying patient preferences, and the lack of generally accepted standards for the appropriate level of cost-effectiveness are among the problems standing in the way. Arnold M. Epstein, *The Outcomes Movement—Will it Get Us Where We Want to Go*, 323 NEW ENG. J. MED. 266, 268-69 (1990). However thorough our empirical database on clinical outcomes, myriad normative choices will be necessary.

349. Ditkoff, *The Future of Health Care: An Economic Analysis*, 41, 44 (Feb. 12, 1985) (unpublished student paper on file with Professor Henry Hansmann at the Yale Law School). The ABC news magazine program *PrimeTime Live* reported on exorbitant prices charged by Humana and raised serious questions about the firm's quality control practices. *PrimeTime Live* (ABC television broadcast, Aug. 8, Aug. 15 & Oct. 24, 1991). Evidence that some private psychiatric hospitals have hired "bounty hunters" to find patients has also been a focus of media attention. *E.g.*, Milt Freudenheim, *The Squeeze on Psychiatric Chains*, N.Y. TIMES, Oct. 25, 1991, at D17.

350. *See, e.g.*, *Schoening v. Grays Harbor Community Hosp.*, 698 P.2d 593 (Cal. 1985) (holding that hospital has duty to monitor staff physicians' treatment of patients and to intervene to prevent obvious negligence).

351. We can anticipate an evolution of the concept of standard of care in medical malpractice law, away from the "do everything" ethic toward a new cost-benefit consciousness in the creation of minimum clinical standards. A detailed study of the likely changes is beyond the scope of this Article. However, one might predict that physicians as witnesses will increasingly stress cost-benefit thinking, supported by data from clinical outcome studies, in explaining why actions at issue were not taken, and that finders of fact will show growing awareness of the cost-benefit balance. If physicians continue to insist on defining standards of care exclusively in terms of what is technically possible and conceivably beneficial (regardless of cost) we might then see a diminution of judicial deference to the profession's standards and a more active judicial role in the definition of clinical negligence.

2. *Overuse of Technology*

Relman and other academic critics of the investor-owned hospital chains allege that the for-profit sector tends to overemphasize technology.³⁵² Their argument is not that the for-profits so overuse technology that patients actually suffer clinical harm. Rather, they assert that investor-owned facilities show a greater tendency than do nonprofits to perform costly procedures of insubstantial diagnostic or therapeutic value.

These critics can point to some supporting evidence. Several studies conducted under cost-plus and charge-based reimbursement conditions document higher total charges for technology-intensive ancillary services at chain-owned, for-profit hospitals than at matched nonprofits.³⁵³ Although some of this difference was due to higher charge-to-cost mark-ups by the for-profits, the absolute number of *units* ordered per admission (or per patient-day) for all profitable ancillary services was greater at chain-owned for-profits than at matched nonprofits.³⁵⁴ Operating in a retrospective reimbursement environment, managers at investor-owned facilities may have successfully encouraged physicians to order profitable but unproven tests and procedures that fall within a grey zone of accepted clinical discretion.³⁵⁵

If so, it is hardly clear that the blame ought to be pinned on the for-profit form. The aggressive promotional efforts of drug companies at least equal those of the investor-owned hospital chains. Yet we generally accept such behavior by pharmaceutical firms and we expect physicians to prescribe medications based only on their own and the profession's independent, critical assessment of therapeutic claims. Why should we expect less of physicians when they make decisions about other hospital-based therapeutic and diagnostic services? If physicians are to serve responsibly as patients' purchasing agents in the medical care marketplace, then any tendency to yield uncritically to the blandishments of

352. See, e.g., Relman, *supra* note 238, at 969; cf. Remarks by D.D. Federman on the impact of for-profit organization on physicians (1983) (unpublished manuscript on file at the Office of the Dean of the Harvard Medical School) (warning that for-profit hospitals will exacerbate pressures on physicians to order unproven but highly profitable diagnostic and therapeutic measures).

353. See, e.g., Pattison & Katz, *supra* note 131, at 349-50; Watt et al., *supra* note 134, at 93-95.

354. Pattison & Katz, *supra* note 131, at 350 (The most "profitable" services at the hospitals studied were clinical laboratories and in-patient pharmacies.).

355. Watt et al., *supra* note 134, at 95; Arnold S. Relman, *Investor-Owned Hospitals and Health-Care Costs*, 309 NEW ENG. J. MED. 370 (1983).

hawkers of hospital-based technology ought to be regarded as a fiduciary failure³⁵⁶ and not dismissed as a creation of the for-profit sector.³⁵⁷

The principal cause of fiduciary failure is the pro-technology bias that has pervaded reimbursement of both doctors and hospitals.³⁵⁸ Medicare and many private insurers pay much higher fees for physician time spent performing technical procedures than for time spent at cognitive clinical tasks.³⁵⁹ Retrospective reimbursement schedules for hospitals—whether cost-plus or charge-based—likewise favor technology-intensive services over labor-intensive, caring services.

Reform of this perversely skewed payment system promises to sharply reduce the problem of fiduciary failure. A basic restructuring is already underway. The growth of prospective, diagnosis-based reimbursement and prepaid, comprehensive health plans is rapidly reducing pro-technology financial incentives at both for-profit and nonprofit hospitals. No longer will hospital managers be tempted to pursue better bottom-line results by enticing physicians to order costly services with little marginal benefit. Studies that document higher usage of ancillary services at for-profit hospitals under *retrospective* payment conditions have little predictive value in the emerging prospective reimbursement climate.

Restructuring of physician reimbursement could provide even greater protection against fiduciary failure. Though pro-technology bias still pervades doctors' fee structures in private practice, increasing numbers of physicians work on a salaried basis, free from financial pressures to overuse technology. Prospective reimbursement for private practitioners, or radically revised fee-for-service schedules that value cognitive and procedural time equivalently would further reduce incentives to deviate

356. By "fiduciary failure," I mean any gap between physicians' clinical service purchasing behavior and society's—or payers' or patients'—quality and cost-benefit expectations. How cost-benefit expectations, or standards, for clinical services should be set (and who should set them) is a question of extraordinary moral, political, and economic complexity, far beyond the scope of this Article, but in the new era of cost-benefit consciousness, physicians, patients, third-party payers, and the courts will be forced to reach some, at least temporary, operational answers.

357. Academic, tertiary care medical centers have also been accused of overusing technology, even to the point of doing more harm than good to some patients. *E.g.*, Steel et al., *Iatrogenic Illness on a General Medical Service at a University Hospital*, 304 NEW ENG. J. MED. 638 (1981); Steven A. Schroeder, *The Complications of Coronary Arteriography: A Problem That Won't Go Away*, 99 AM. HEART J. 139 (1980). Critics of technology use at academic centers point to pro-technology reimbursement biases, see *infra* text accompanying notes 358-60, and the "monotechnic," cost-insensitive ideal of quality discussed earlier, *supra* note 339.

358. Cf. Schroeder, *supra* note 299, at 636-37 (Pro-technology reimbursement bias is the most important influence on use of medical technology.).

359. *Id.*; *supra* text accompanying notes 59-61.

from the fiduciary role. Recent legislation instructs the HCFA to develop a physicians' Medicare fee schedule that incorporates higher-than-traditional valuations for cognitive time and lower valuations for procedural time. This represents an important step toward restructuring physician payment to reduce fiduciary failure.³⁶⁰

Academic medical centers could play an invaluable educational role by encouraging physicians-in-training to adhere to a more cost-conscious fiduciary ethic. Greater emphasis on the teaching of statistical and economic concepts and new attention to the nurturing of critical habits of mind could better prepare future practitioners to assess risks, costs, and probabilities of benefit.³⁶¹

In short, a tendency to overuse technology-intensive services is not inherent in the for-profit hospital sector. The physician as fiduciary bears responsibility for the ordering of clinical services. Restructuring reimbursement incentives and modifying medical education would promote the physician's effectiveness as a fiduciary in his or her dealings with a hospital.

3. *Destabilizing Effects*

The Harvard faculty panel that recommended rejection of HCA's bid to purchase McLean Hospital concluded its report with a curious warning. Sale of McLean to HCA, the panel said, "would have had serious destabilizing effects on the six departments of psychiatry at Harvard. These departments compete with each other for faculty, trainees and research support, and the new resources this proposal would have generated for McLean would have changed the competitive balance."³⁶²

This warning acknowledged a fear that has not been addressed in the published debate about the for-profits. The social structure of academic medicine today is largely a product of the NIH grant-making process and the lucrative clinical programs that have fueled the academic sector's extraordinary growth in the last four decades.³⁶³ Mores by which opportunity, rank, and privilege are bestowed have developed as an integral part of this growth. Effectiveness at tailoring one's work to the opportunities and pitfalls of short-term grant making by peer review and success in developing new and lucrative clinical services have been

360. However, the relative value scale that will serve as the basis for this fee schedule retains substantial pro-technology bias in its valuations of procedural and cognitive time.

361. See *supra* note 299.

362. Faculty Advisory Committee Report, *supra* note 6.

363. See *supra* text accompanying notes 47-68.

central to the cultivation of an academic career. The current leaders of academic medicine climbed to their places within this system's constraints. Like most who have committed their lives to success within a system's confines, they are wont to believe intensely in the system's legitimacy and to expect others to abide by its constraints.

New opportunities created by an infusion of funds from the for-profit sector into some academic centers could transform the rules of the game. Compliance with current mores and patterns of deference could become less important for career advancement.³⁶⁴ The resulting disruption of the social structure of academic medicine could become severe. Already, tensions exist between fiscally troubled institutions interested in improving their academic standing by tapping the for-profits' resources and elite centers which are so well supported by conventional resources (NIH grants, private philanthropy, and clinical income) that they can maintain their prestige while eschewing ties with the for-profits.³⁶⁵ Resentment could also brew at financially struggling institutions left without for-profit partners. Even at institutions reaping the benefits of links with the for-profits, individuals who have succeeded within the established system's constraints might perceive their accomplishment as devalued and their status as threatened by new paths to achievement.

If academic medicine is to be valued based on the social utility of its output, however conceived, then such protectionist sentiment ought to have no place in any weighing of the merits of allowing for-profit firms onto campus. The worries of an elite faced with a threat to its prerogatives should not be equated with the interests of either the medical profession as a whole or the larger society. A social hierarchy that unduly restrains development of new ideas and opportunities out of deference to such an elite *ought* to be disrupted—in academic medicine no less than at

364. For example, prolonged apprenticeship with a grant-holding senior researcher is a generally necessary step along the path to a young academic physician's first research grant in his or her own name. First-time NIH Principal Investigators (recipients of research grants in their own names) are usually their late thirties or older. Until a researcher receives a grant in his or her own name, he or she is subject to a grant-holding senior researcher's authority, which is virtually absolute. The young researcher's future career opportunities depend almost entirely on this supervisor's impressions, and his or her research agenda is entirely subject to this supervisor's will. The NIH grant system thus engenders a remarkably authoritarian social structure, protective of the prerogatives of established individuals and hardly conducive to freedom for young scientists to pursue novel ideas. New resources generated from arrangements between academic centers and for-profit firms could provide young scientists with the means to pursue their ideas without enduring a long period of deference to senior grant-holders.

365. See, e.g., *supra* note 20 (A George Washington University official characterizes elite academic critics' objections to his own institution's talks with the for-profits as contempt by the "haves" for the struggles of the "have-nots.").

a faltering industrial corporation. No plausible public policy rationale exists for freezing current "competitive balances" between academic centers or blocking off new routes to individual accomplishment merely to preserve the status of an established elite.³⁶⁶

4. *Altruism and the Nurturing of Community*

Some critics of investor-owned hospital services assert that by providing a focus for neighborly, altruistic feeling, nonprofit hospitals nurture a sense of community.³⁶⁷ Donations of money and services to a community hospital affirm and sustain the community's sense of mutual caring. In contrast, by transforming medical care into a service exchangeable for economic gain, for-profit hospitals strain this communal sense. This intuition about the relationship between altruism and community has been most fully developed by Richard Titmuss.³⁶⁸ Titmuss argues that altruistic experiences, especially those that save lives, pull persons together into a community, while market transactions do not.³⁶⁹ Communal solidarity is nurtured when people recognize the potential for reciprocity—today's charitable giver may be tomorrow's beneficiary. Potentially lifesaving gifts come to represent life itself. In contrast, the exchange of lifesaving goods and services for money invites potential donors to equate the value of lifesaving gifts with their price instead of with life. Communal perceptions of potential reciprocity are thereby destroyed, and community solidarity is eroded.

366. Nevertheless, opposition to frank protectionism should be tempered by awareness that the prestige and autonomy of academic medicine's elite can serve an important public purpose as ties develop between academic centers and the for-profits. That prestige can be a potent counterweight to the power a large, for-profit enterprise will inevitably possess in its relationship with an academic center; it can be wielded in sale and leasing negotiations to win safeguards for researchers' work from the encumbrances and pressures of the for-profit partner's management. *See infra* text accompanying notes 532-39. Once a deal is consummated, academic medicine's public prestige is likely to weigh heavily in the minds of corporate managers who might otherwise be tempted to infringe upon these safeguards. *See supra* text accompanying notes 204-05. But that prestige rests ultimately upon academic medicine's accomplishments, not on anticompetitive behavior.

367. David Rosner, *Heterogeneity and Uniformity: Historical Perspectives on the Voluntary Hospital*, in *IN SICKNESS AND IN HEALTH* 87 (David Seay & Bruce Vladeck eds., 1988); cf. Daniel Wikler, *The Virtuous Hospital: Do Nonprofit Institutions Have a Distinctive Moral Mission*, in *IN SICKNESS AND IN HEALTH*, *supra*, at 127 (arguing that the history, ideology, habits, and reputation of nonprofit hospitals incline them toward altruism and virtue even if they often fail to achieve it).

368. RICHARD M. TITMUSS, *THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY* (1971).

369. *Id.* at 237-46; cf. Radin, *supra* note 234, at 1913 (citing Titmuss approvingly in support of her argument that goods and services expressing feelings central to personhood should not be "commodified" via market transactions).

Titmuss's portrayal of the relationship between giving and community is affecting. He has captured an aspect of the experience of altruism not fully acknowledged by his utilitarian critics.³⁷⁰ But it has almost no relevance to the modern nonprofit hospital. Unlike its nineteenth century predecessor,³⁷¹ the modern nonprofit hospital is essentially a commercial enterprise.³⁷² Almost all of its revenues represent payment for services rendered.³⁷³ Virtually all of its factors of production—its physical plant, equipment, supplies, and labor force—are purchased in the marketplace from income-seeking firms and individuals. The long-term debt market has supplanted charitable donors as its major capital source.³⁷⁴ Vestiges of altruism remain—blood and organ donors, small financial contributions, and some volunteers. But altruism generates only a tiny fraction of the modern nonprofit hospital's resources.

For many Americans, the local nonprofit hospital is no more a place for altruistic experience and the nurturing of community than the local shopping mall. The average person is a paying customer of each. Acquisition of the hospital by an investor-owned firm would pose only a minimal threat to the community's sense of mutual caring because the local, nonprofit hospital makes only a minimal contribution to it. The demise of the nonprofit hospital as a community-affirming, charitable institution is a loss worth mourning. But insistence that hospitals retain the nonprofit form will not undo this loss.

In sum, the moral, economic, and other policy concerns reviewed in this section are not persuasive as threshold objections to the operation of teaching hospitals by investor-owned firms. Allowing investor-owned hospitals onto the academic medical campus carries genuine risks, but these can be effectively managed through the design and implementation of contractual safeguards.³⁷⁵ If this is done, academic medical centers seriously in need of new financial support can reap benefits for themselves and society that outweigh the risks of these arrangements.

370. See, e.g., Kenneth J. Arrow, *Gifts and Exchanges*, 1 PHIL. & PUB. AFF. 343 (1972).

371. CHARLES E. ROSENBERG, *THE CARE OF STRANGERS* 15-121 (1987).

372. Hansmann, *supra* note 276, at 866-67.

373. G. ANDERSON ET AL., *PROVIDING HOSPITAL SERVICES: THE CHANGING FINANCIAL ENVIRONMENT* 147-48 (1989) (reporting that philanthropy represented less than 1.3 percent of funds used for hospital care in 1985).

374. D. COHODES & B. KINKEAD, *HOSPITAL CAPITAL FORMATION IN THE 1980s* (1984).

375. See *infra* text accompanying notes 508-86 (presenting recommendations for the development of contractual arrangements that achieve favorable ratios of benefits to risks, viewed from the perspectives of both academic medicine and the public interest).

VI. THE LEGAL LANDSCAPE: SOME PRACTICAL CONSIDERATIONS

In general, no insurmountable legal barrier blocks the acquisition or leasing of teaching hospitals by investor-owned corporations. Those who design and execute such arrangements, however, must take into account myriad regulatory and legal considerations. Many of these concerns are hardly unique to takeovers of teaching hospitals by for-profit firms. They are, rather, generic to a wide range of ventures³⁷⁶ in the highly regulated hospital industry. Two problem areas, however, could pose more particular pitfalls for teaching centers and for-profit health systems interested in purchase or leasing deals. One is the array of tax consequences resulting from any such arrangement. The other is the duty of nonprofit corporation trustees to comply with restrictions on the use of gifts, bequests, and other donated resources held in trust. After briefly identifying some generic regulatory considerations,³⁷⁷ I will discuss these two problem areas in some detail. The following discussion presumes the conclusion of the previous section—that threshold policy arguments against the operation of teaching hospitals by for-profit firms are not persuasive, and that the benefits of such arrangements, if well-designed, outweigh the hazards. Accordingly, I review the potential legal obstacles to sale and leasing agreements from a perspective favorable to these agreements' success. Where ambiguous "black letter" law can be applied so as to either facilitate or thwart well-designed arrangements, the weakness of threshold public policy arguments against such arrangements warrants a permissive approach.

The primary purpose of this section is to evaluate the possibility that various legal and regulatory requirements will be applied in a non-permissive manner. My limited aim here is to offer a legal and regulatory risk assessment for transacting parties (e.g., nonprofit sellers, for-profit purchasers, and affiliated universities); this section is not an exercise in normative scholarship regarding the myriad issues it addresses. The

376. Examples include other changes in hospital ownership (especially purchases of nonteaching, community hospitals by the for-profits), corporate or administrative restructuring of nonprofit hospitals, development of new clinical services, and new construction programs.

377. These considerations reflect the complex and intensive state and federal regulatory environment within which all hospitals must operate. A thorough discussion of these regulatory matters would require an excursion into broad areas of hospital law, an undertaking far beyond the scope of this project.

discussion is practical in emphasis and intended to assist transacting parties in appraising and overcoming legal and regulatory obstacles. Readers with little interest in these problems can skim quickly through this section or even skip it entirely.

A. SOME GENERIC REGULATORY CONCERNS

An array of state, federal, and even private regulatory schemes constrains the capital spending and organizational form of nonprofit and for-profit hospitals. These constraints may bear in varying ways upon purchase and leasing agreements between for-profit firms and academic medical centers.

Expansion and facility improvement programs, ranging from construction of a new building to acquisition of a new technology to the opening of new clinical services, must in many states be approved by regulatory bodies charged with regional coordination of medical services and avoidance of overcapacity.³⁷⁸ Construction and capital-improvement programs linked to acquisition or leasing deals between teaching centers and the for-profits will need to survive this regulatory scrutiny.³⁷⁹

378. In states imposing this regulatory requirement, a health services facility must obtain a "Certificate of Need" (CON) from a state administrative agency in order to proceed with new construction or certain other capital improvement programs. The vagueness of "need" as a criterion for project approval has led to protracted litigation and long delays in the CON process. Agency decisions to grant CONs are frequently challenged in court by the CON recipients' competitors. When state regulators deny CONs, they are often challenged in court by the CON applicants. Regulators pursue multiple, often conflicting policy objectives under the CON rubric. These include cost-containment, provision of services to the medically indigent, improved geographic access to care, and even the strengthening of competition. James R. Simpson, *Full Circle: The Return of Certificate of Need Regulation of Health Facilities to State Control*, 19 IND. L. REV. 1025 (1986); Sallyanne Payton & Rhoda M. Powsner, *Regulation Through the Looking Glass: Hospitals, Blue Cross, and Certificate-of-Need*, 79 MICH. L. REV. 203 (1980).

The problems raised by the exercise of broad administrative discretion in the CON context are akin to those arising under other regulatory schemes calling for allocation of scarce resources—e.g., radio and television broadcasting frequencies, authority to fly commercial air routes—according to a general, public interest standard. See STEPHEN G. BREYER, *REGULATION AND ITS REFORM* 71-95 (1982) (discussing conflicts between regulators' aspirations to achieve various forms of procedural and substantive fairness as well as conflicting public policy objectives).

379. A 1984 agreement between Humana and the Chicago Medical School to construct and operate a new teaching hospital was ultimately abandoned because Humana failed to obtain the necessary state approval—a "Certificate of Need" (CON). The agreement, which called for Humana to build, own, and operate a 224 bed tertiary care center near Chicago, met stiff opposition from area community hospitals and from critics of investor-owned medical services. A coalition of community hospitals (potential competitors of the proposed Humana facility) opposed Humana's 1984 CON application and appealed a state health planning board's 1986 decision to grant a CON to Humana. After two years of litigation over a myriad of issues of administrative procedure, the Illinois Supreme Court issued a ruling reversing a lower court's dismissal of much of the coalition's complaint and remanding the case to the lower court for trial. *Condell Hosp. v. Illinois Health Facilities Planning*

These regulatory programs do not openly distinguish between for-profit and nonprofit hospitals in evaluating proposals for capital improvements. But fears about the investor-owned chains' avowedly profit-making orientation could inspire members of regulatory bodies to engage in more exacting scrutiny of proposals from for-profit facilities. Because perceived capital-improvement needs are often the impetus for academic centers to consider links with the for-profits, teaching center managers would do well to explore regulators' attitudes toward for-profit operation of their facilities. Informal contacts with regulatory personnel as well as observations of past behavior patterns in response to submissions by nonprofit and for-profit community hospitals could provide useful information in this regard.

In addition, state licensing agencies (generally state departments of health) typically prescribe a variety of organizational requirements for all inpatient facilities.³⁸⁰ Moreover, the Joint Commission on Accreditation of Health Care Organizations (JCAHO), a "private" body whose accreditation is in practice essential for continued hospital operations, has established detailed organizational standards for hospital managers and directors.³⁸¹ At the federal level, Medicare's "Conditions of Participation" require that inpatient facilities reimbursed by Medicare possess "an effective governing body legally responsible for the conduct of the hospital as an institution."³⁸² The JCAHO and licensing regulations in many states likewise mandate such a governing body for each individual hospital.³⁸³

These organizational requirements have in practice posed little practical difficulty for the investor-owned hospital chains. At hundreds of nonteaching, community hospitals operated by the chains, management

Bd., 124 Ill. 2d 341 (1988). Faced with the prospect of years of further litigation to finalize its CON, Humana abandoned the project. Interview with Wendell Potter, Senior Public Affairs Manager, Humana Inc. (Nov. 1990).

380. John F. Harty & Daniel M. Mulholland III, *Legal Differences Between Investor-Owned and Nonprofit Health Care Institutions*, in *THE NEW HEALTH CARE FOR PROFIT: DOCTORS AND HOSPITALS IN A COMPETITIVE ENVIRONMENT* 17, 19 (Bradford H. Gray ed., 1983).

381. JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, *ACCREDITATION MANUAL FOR HOSPITALS* (1982) [hereinafter JCAHO].

382. 42 C.F.R. § 405.1021.

383. JCAHO, *supra* note 381, at 51; Harty & Mulholland, *supra* note 380, at 22. As Harty and Mulholland observe, the significance of a hospital governing body's legal responsibility has been made real during the last few decades by a series of court decisions holding these bodies responsible for hospitals' quality of care (even when care is provided by non-employed physicians permitted to practice in a hospital), *see, e.g.*, *Darling v. Charleston Community Memorial Hosp.*, 211 N.E.2d 253 (Ill. 1965), and fiscal integrity, *e.g.*, *Stern v. Lucy Webb Hayes Nat'l Training Sch. of Deaconesses & Missionaries*, 381 F. Supp. 1003 (D.D.C. 1974).

has been able to fashion administrative arrangements acceptable to state regulators, the JCAHO, and Medicare. In particular, the for-profits have adopted the practice of delegating broad management responsibilities to semi-autonomous, local governing boards at each hospital, composed of physicians, community representatives, and corporate officials. Though not ultimately responsible in a legal sense for capital investment and other management decisions, these boards exercise authority over professional matters such as the conferring of admitting privileges and the organization of clinical support services. Chain officials claim these bodies also have considerable say in the preparation of operating budgets, the planning of capital expenditures, and even the selection of hospital administrators.³⁸⁴ Their authority has been deemed sufficient by the JCAHO and other regulatory entities. Similar organizational arrangements at chain-operated teaching hospitals (including provisions for substantial medical school faculty and administration representation on the governing boards³⁸⁵) should suffice to meet the requirements of these regulatory bodies.³⁸⁶

Nevertheless, local regulatory considerations may in some cases rule out the sale or leasing of a teaching hospital to an investor-owned firm. Some states have regulatory barriers to market entry that make it extremely difficult in practice for investor-owned firms to acquire hospitals.³⁸⁷ Activists in some other states have been pressing for legislation to freeze or restrict further hospital acquisitions by the for-profits. Some

384. See, e.g., Remarks of John Bedrosian, President of National Medical Enterprises (NME), in *Relman-Bedrosian Debate*, *supra* note 237, at 34-35. According to Bedrosian, members of an NME hospital's medical staff typically constitute two thirds of the hospital's board, and medical staff rules, regulations, and credential requirements are established solely by members of the staff. New hospital administrators are selected by the board from a list of two to four candidates submitted by NME. *Id.* A study of four nonteaching hospitals recently sold to investor-owned chains found a generally high level of satisfaction among physicians as to their role in management decisions and on the local board at three of the four hospitals. Jessica Townsend, *supra* note 189, at 61-62.

385. For example, in its talks with George Washington University about a possible purchase or lease of the George Washington University Hospital, American Medical International, Inc. proposed a seven person governing board that would have included four senior university officials. See AMI Letter, *supra* note 210, app. I.

386. The organizational requirements imposed by these regulatory entities do not differ significantly for teaching and nonteaching hospitals. In formulating governance mechanisms at investor-owned (or leased) teaching centers, however, corporate and academic officials will also need to consider the requirements of the clinical specialty and subspecialty bodies that accredit particular residency and fellowship programs.

387. For example, a New York statute requires investor-owned chains to overcome a variety of difficult obstacles to obtain the discretionary approval of an administrative entity that regulates hospital incorporation, establishment, and ownership. N.Y. PUB. HEALTH LAW § 2808-a (McKinney 1985).

state universities, moreover, may not be able to sell or lease their hospitals to private parties without obtaining authorization from the state legislature, the executive, or an administrative agency.³⁸⁸ Before starting talks with a for-profit chain, the managers of an academic center actually or potentially affected by such restrictions ought to assess carefully the legal and political options, including the inclinations of political actors with the power to permit or prevent a deal.

A more speculative regulatory concern is the growing antitrust activism of the courts and the Federal Trade Commission (FTC) in the health care field.³⁸⁹ Aggressive antitrust enforcement could complicate the for-profits' strategic plans to make teaching centers into regional hubs within comprehensive, vertically integrated health care networks. The U.S. Supreme Court opened the way for application of federal antitrust law to the hospital industry in 1976 when it held that hospital operations have a "substantial effect" upon interstate commerce and are thus subject to the jurisdiction of the Sherman Act.³⁹⁰ For prospective purchasers of teaching hospitals, the federal antitrust statute of primary concern is section 7 of the Clayton Act, which proscribes acquisitions that "may . . . substantially . . . lessen competition, or . . . tend to create a monopoly."³⁹¹ Neither this nor any other antitrust provision has been applied thus far to an acquisition of a teaching institution by a for-profit hospital chain. However, the courts and the FTC have recently invoked section 7 to thwart mergers between chains as well as chain acquisitions

388. Cf. Howard Waitzkin et al., *Deciding Against Corporate Management of a State-Supported Academic Medical Center*, 315 NEW ENG. J. MED. 1299 (1986) (presenting a plan by AMI and University of California at Irvine for AMI to build, own, and manage a new teaching hospital rejected by University of California system's central administration after state legislators and Orange County officials, among others, expressed opposition).

389. See generally Michael R. Pollard, *The Essential Role of Antitrust in a Competitive Market for Health Services*, 59 MILBANK MEMORIAL FUND Q. 256 (1981) (briefly reviewing the application of antitrust principles to health care providers and arguing for discriminating antitrust activism where professional self-regulation has been abused in pursuit of economic self-interest); Clark C. Havighurst, *Antitrust Enforcement in the Medical Services Industry: What Does It All Mean?*, 58 MILBANK MEMORIAL FUND Q. 89 (1980) (more extensively surveying antitrust activity in the health field and arguing for broad "antitrust attack on the medical citadel" in lieu of reliance on provider self-regulation).

390. *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 425 U.S. 738, 744-46 (1976) (holding a proprietary hospital to be within flow of interstate commerce because it purchased medicines and supplies and received insurance reimbursement from out-of-state sources, paid a management fee to an out-of-state parent corporation, and was a potential recipient of out-of-state financing).

391. 15 U.S.C. § 18 (1983). The jurisdictional requirement under this provision is identical to that under the Sherman Act. ABA ANTITRUST SECTION, ANTITRUST LAW DEVELOPMENTS 148 n.4 (2d ed. 1984).

of freestanding community hospitals.³⁹² The focus in these cases has been on the hazards of horizontal consolidation. But vertical integration could become a locus of attention in section 7 litigation.

Section 7 actions may be brought by the U.S. Department of Justice, the FTC,³⁹³ state attorneys general,³⁹⁴ or any private party allegedly injured or—where injunctive relief is sought—threatened with harm³⁹⁵ by a violation. Analysis under section 7 begins with definition of the “relevant market” in both geographic and product-group terms. When addressing the lawfulness of mergers and acquisitions in the hospital industry, the FTC and the courts have eschewed consideration of national market shares in favor of a local approach to the geographic definition of relevant markets. Guided by regional patient-flow data,³⁹⁶ they have designated cities or other local areas as relevant market

392. See, e.g., *United States v. Hospital Affiliates Int'l, Inc.*, 1980-81 Trade Cas. (CCH) ¶ 63,721 (E.D. La. 1980) (blocking a merger of psychiatric hospital chains because it would have created a firm with monopoly shares of psychiatric beds and patient days in the relevant market in violation of section 7); *American Medical Int'l, Inc.*, 3 Trade Reg. Rep. (CCH) ¶ 22,170 (1984) (FTC finding that acquisition of single facility by a hospital chain substantially lessened competition in the relevant market, in violation of section 7; the FTC ordered divestiture).

393. HEALTH LAW CENTER, II HOSPITAL LAW MANUAL Antitrust, ¶ 11-2 (Dec. 1984) [hereinafter HOSPITAL LAW MANUAL]. The FTC may petition the courts for a temporary restraining order or preliminary injunction. *Id.*

394. 15 U.S.C. § 15c (1988); see also HOSPITAL LAW MANUAL, *supra* note 393, Antitrust, ¶ 11-3 (discussing the enforcement of state and federal antitrust law by state attorneys general against health-related enterprises).

395. To establish standing to assert a claim, a private plaintiff must show injury to its business or property. Moreover, the plaintiff must demonstrate a causal relationship between the injury and the alleged violation. 15 U.S.C. § 15 (1988); see also HOSPITAL LAW MANUAL, *supra* note 393, Antitrust ¶ 11-4 (discussing requirements for a showing of injury to a private party). Where injunctive relief is sought to prevent an acquisition, proof of *threatened* loss or damage may suffice for the injury prerequisite. *Id.*

Thus many who might object to a for-profit's acquisition of a teaching hospital—e.g., medical school faculty members, civic leaders, and politicians—will lack the direct economic nexus necessary to formulate an attack under federal antitrust law.

396. Courts and the FTC have studied data on, *inter alia*, the geographic distribution of patients and physicians who use particular hospitals within a region and the hospital choices of patients and physicians from particular areas within a region.

regions.³⁹⁷ They have defined the relevant product group as acute general hospital services.³⁹⁸ It is possible, however, that in a section 7 challenge to the acquisition of a teaching hospital, the product group could be more narrowly defined as tertiary care services.³⁹⁹

The next analytic step is to quantitatively assess concentration in the relevant market before and after the acquisition at issue. The market shares of significant competitors, including those involved in the challenged acquisition, are figured from available industry data.⁴⁰⁰ The courts and the FTC have refrained from establishing strict numerical criteria for illegal increases in market concentration.⁴⁰¹ The Department of Justice, though, has developed general guidelines based upon a simple mathematical formula for estimating the impact of concentration on

397. See, e.g., *American Medical Int'l, Inc.*, 104 F.T.C. 1 (1984) (designating the relevant market as a city); *United States v. Hospital Affiliates Int'l, Inc.*, 1980-81 Trade Cas. (CCH) ¶ 63,721 (E.D. La. 1980) (designating planning regions, known as Health Systems Agency areas, established pursuant to the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k-3001 (1988)); *American Medicorp, Inc. v. Humana, Inc.*, 445 F. Supp. 589 (E.D. Pa. 1977) (designating the relevant market as Health Systems Agency Areas). The 1984 merger guidelines issued by the U.S. Department of Justice define the relevant geographic market or markets as the smallest area(s) "for which a hypothetical monopolist could profitably impose a 'small but significant and nontransitory' increase in price." U.S. DEPT. OF JUSTICE MERGER GUIDELINES Guideline 2.11, reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,103 (No. 655 Part II) (June 14, 1984) [hereinafter GUIDELINES].

398. See, e.g., *American Medicorp, Inc. v. Humana, Inc.*, 445 F. Supp. 589, 597-98 (E.D. Pa. 1977); *American Medical Int'l, Inc.*, 3 Trade Reg. Rep. (CCH) ¶ 22,170 (1984).

399. Courts have articulated a so-called "reasonable interchangeability" standard for specification of the relevant product group in Clayton and Sherman Act antitrust actions. "The essential test for ascertaining the relevant product market involves the identification of those products or services that are either (1) identical to or (2) available substitutes for the defendant's product or service." *White & White, Inc. v. American Hosp. Supply Corp.*, 723 F.2d 495, 500 (6th Cir. 1983). This standard offers little real guidance to courts faced with the task of drawing a line between reasonable and unreasonable interchangeability in a complex marketplace of imperfect substitutes like hospital services. The Justice Department's 1984 merger guidelines are one attempt to provide some additional guidance. They define the relevant product group as the most narrowly circumscribed group of substitutes "for which a hypothetical monopolist could profitably impose a 'small but significant and nontransitory' increase in price." GUIDELINES, *supra* note 397. Under this definition, it is arguable that hospital-based *tertiary care services*—a grouping more circumscribed (and more highly priced) than all general hospital services—ought to constitute the relevant product group in the hypothetical case of a Clayton Act section 7 action to block the purchase of a teaching center by a for-profit chain.

400. In the hospital industry shares of the relevant market's total of beds and inpatient days are typically calculated. See, e.g., *United States v. Hospital Affiliates Int'l, Inc.*, 1980-81 Trade Cas. (CCH) ¶ 63,721, at 77,853 (E.D. La. Oct. 9, 1980).

401. However, where a merger of hospital chains gave the acquiring firm a 72.9 percent share of the psychiatric beds and a 72.3 percent share of the patient days in a relevant market (roughly doubling the firm's market share) a court found these shares to be of "monopoly proportions" in violation of section 7. *Id.*

competition in a market.⁴⁰² The FTC recently adhered to these guidelines in ordering a hospital chain to divest itself of a newly acquired facility.⁴⁰³

The final step is to consider the market concentration before and after the challenged acquisition along with a number of qualitative factors to determine whether the acquisition "substantially lessens competition" or "tends to create a monopoly" in violation of section 7. These factors include barriers to market entry (such as regulatory and financial requirements),⁴⁰⁴ overall industry trends toward concentration, and the acquisition's impact on nonprice⁴⁰⁵ and potential⁴⁰⁶ competition. The efficiency gains that result from an acquisition may be found to offset other, anticompetitive effects.⁴⁰⁷

402. The formula, known as the Herfindahl-Hirschman Index (HHI), is the summation of the square of each competitor's share in the relevant market. GUIDELINES, *supra* note 397, Guideline 3.1. The squaring feature models the premise that anticompetitive behavior by a market participant becomes much more likely as its market share increases. Under the Justice Department's guidelines, acquisitions resulting in an HHI below 1000 are unlikely to be challenged. Where the post-acquisition HHI is in the 1000 to 1800 range, a challenge is unlikely if the HHI increase resulting from the acquisition is less than one hundred, but is more likely (depending on other factors) if the increase is more than one hundred. Where the post-acquisition HHI is greater than 1800 and the acquisition-related increase is more than one hundred, a challenge is likely. However, if the increase is in the fifty to one hundred range, a decision to challenge will depend on other factors, and if the increase is less than fifty a challenge is unlikely. *Id.*

403. American Medical Int'l, Inc., 3 Trade Reg. Rep. (CCH) ¶ 22,170 (1984). The Commission found that the post-acquisition Herfindahl-Hirschman Index (HHI) for the relevant market, *see supra* note 402, was well above 1800 and had risen by more than one hundred as a result of the acquisition. These figures met the Justice Department's HHI thresholds for a likely challenge to an acquisition. *See* GUIDELINES, *supra* note 397, Guideline 3.11.

404. The requirement in many states of a Certificate of Need (CON), *see supra* note 378, for expansion of an existing hospital or construction of a new facility is the principal regulatory obstacle to entry. The CON barrier has been cited by the FTC as an important qualitative indicator that a hospital acquisition may lessen competition. American Medical Int'l, Inc., 3 Trade Reg. Rep. (CCH) ¶ 22,170, at 23,044 (1984).

405. The FTC has cited efforts to attract medical staff as one form of nonprice competition reduced by a hospital chain's acquisition of a free-standing facility. *Id.* at 23,047-48.

406. The FTC has indicated in dictum that the possible emergence of a market for group hospital service contracts, sought out by independent, prepaid health plans, represents one area of potential competition deserving of consideration in an assessment of an acquisition's lawfulness under section 7. *Id.* at 23,048-51 (citing the predicted development of demand by health maintenance and preferred provider organizations for group hospital contracts but concluding that the acquisition at issue did not reduce potential competition to meet this demand because there was no evidence that such prepaid plans had established a significant presence in the relevant market).

407. The Supreme Court has indicated in dictum that efficiency gains achieved through a merger of relatively small competitors may *enhance* competition in a market dominated by a larger firm. *United States v. Von's Grocery Co.*, 384 U.S. 270, 277-78 (1966). The Justice Department's 1984 Merger Guidelines go further by suggesting that efficiency gains, if shown by "clear and convincing" evidence and not achievable by other means, may *in themselves* justify a decision not to challenge a merger or acquisition. GUIDELINES, *supra* note 397, Guideline 3.5. The FTC has

The significance of hospital chains' vertical integration for Section 7 analysis has not yet been squarely addressed by the FTC or the courts. But the general principles animating antitrust analysis of vertical integration in other industries ought to be similarly applicable to health care delivery. In assessing vertical consolidation, the courts have focused principally on its horizontal effect—its impact on competition in “relevant markets.” Specific factors cited by courts as relevant to evaluation of this impact include the shares of upstream and downstream markets rendered inaccessible to competitors because of intrafirm supply links, the degree of concentration in these upstream and downstream markets, industry trends toward vertical integration, and offsetting efficiency gains.⁴⁰⁸

The many factors to be weighed in section 7 analysis and the wide range of conceivable fact situations involving teaching hospitals make it impossible to state general rules about the outcome of a section 7 challenge. However, where the would-be purchaser already owns a substantial share of the hospital beds in a metropolitan area and quantitative estimates of pre- and postacquisition concentration in the relevant market meet the Justice Department's criteria for a probable challenge,⁴⁰⁹ those involved in planning a deal ought to anticipate the prospect of a successful challenge, given the industry's high regulatory barriers to entry and trends toward horizontal and vertical consolidation.⁴¹⁰ On the other hand, if the would-be buyer can show that acquiring a hospital is necessary to avert the facility's impending financial collapse, judicial approval is likely under the so-called failing company defense.⁴¹¹

employed the Justice Department's approach in assessing the lawfulness of a hospital acquisition. *See American Medical Int'l, Inc.*, 3 Trade Reg. Rep. (CCH) ¶22,170, at 23,055 (1984) (failing to find “clear and convincing” evidence of efficiencies outweighing the acquisition's anticompetitive impact).

The lack of reported, empirical evidence that the for-profit hospital chains achieve greater operating efficiencies than do nonprofit hospitals, *see supra* text accompanying notes 134-38, suggests that gains in *operating* efficiency are unlikely, in general, to be seen as an offset against anticompetitive effects in section 7 actions against the chains. However, the chains' demonstrated advantage over non-profits in the capital markets, *see supra* text accompanying notes 138-41, could be viewed by the FTC and the courts as a competition enhancing efficiency in section 7 cases, particularly where the acquired hospital is a teaching center beset by unmet capital needs.

408. *See, e.g., United States Steel Corp. v. FTC*, 426 F.2d 592 (6th Cir. 1970).

409. *See supra* notes 402-04 and accompanying text.

410. Under such circumstances, a successful challenge would be even more likely if the acquiring firm also had a substantial position in the “downstream” prepaid health plan market.

411. *See Citizen Publishing Co. v. United States*, 394 U.S. 131 (1969) (holding that the failing company defense is applicable only if the acquired firm probably would have been unable, in the near-term future, either to meet its financial obligations on its own or to reorganize successfully).

B. SOME TAX CONSIDERATIONS

Federal and state tax considerations pose no insurmountable barriers to purchase or lease arrangements of the type considered herein. However, prospective for-profit and nonprofit parties to such arrangements must carefully assess the tax consequences of alternative institutional designs in order to plan effectively. By virtue of their substantial influence upon the financial attractions of alternative transaction structures, income and property tax liabilities and exemptions are likely to weigh significantly in the parties' development of negotiating strategies. A thorough tax analysis is beyond the scope of this Article, but I will identify some key issues.

1. *Federal Income Tax*

Federal income tax liability is probably the most important tax consideration for prospective parties to hospital purchase or leasing agreements.⁴¹² Without question, teaching hospital operations sold or leased to a for-profit firm will lose their exempt status.⁴¹³ They will become liable for corporate income tax, will not be able to issue tax-exempt bonds, and will no longer qualify for tax-deductible contributions.⁴¹⁴ But the federal tax consequences are less clear-cut for nonprofit sellers or lessors and for private academic institutions conducting educational and research activities at teaching hospitals owned or leased by for-profit firms.⁴¹⁵

A sale or lease itself should not endanger the seller or lessor organization's exemption from corporate income tax or eligibility for deductible contributions, provided that the organization, after giving up its hospital operations, pursues another purpose that is statutorily permissible in the

412. Determination of exemption from state income taxation will in general closely follow the federal finding. D. WARREN, *PROBLEMS IN HOSPITAL LAW* 314 (3d ed. 1978).

413. See I.R.C. § 501(c)(3) (1988) (exemption for "charitable" institutions). Since 1969 the IRS has construed the word "charitable" to apply to *all* hospitals organized as nonprofits, so long as they (1) do not discriminate among paying patients and (2) operate emergency departments open to all without regard to ability to pay, irrespective of whether they provide below cost inpatient care to the medically indigent. Rev. Rul. 69-545, 1969-2 C.B. 117. This stretched construction has won judicial approval. *Eastern Ky. Welfare Rights Org. v. Simon*, 506 F.2d 1278, 1288-89 (D.C. Cir. 1974), *vacated*, 426 U.S. 26 (1976).

414. I.R.C. § 170 (1988) (Contributions to qualifying nonprofit organizations may be deducted from an individual's income before figuring his federal income tax.).

415. If, however, the seller or lessor (or the institution conducting teaching or research at the hospital after a deal) were a government-owned entity—for example, a state university—it would thereby be automatically exempted.

Internal Revenue Service's view.⁴¹⁶ This restriction imposes few real limits on what the organization may do.⁴¹⁷ If the seller or lessor is a private university, its ongoing educational and research activities will of course qualify it for continued exemption and receipt of deductible contributions. If it is a religious, fraternal, or social service organization, it should qualify by virtue of other ongoing activities in service of its mission. Even a nonprofit firm that exists prior to a sale or lease only for the purpose of operating a hospital should have no difficulty qualifying should it choose to continue in another incarnation—for example, as a foundation for the support of medical education, research, or other health-related activities.⁴¹⁸

The Internal Revenue Service, however, may scrutinize a lease agreement to determine whether the rent paid by the for-profit firm is sufficient to satisfy the statutory proscription against inurement of a tax-exempt entity's "net earnings" to the benefit of private interests.⁴¹⁹ If an agreement failed to survive this scrutiny, the lessor would be forced to choose between maintaining its tax-exempt status and preserving the agreement. In practice, IRS scrutiny is likely to entail an assessment of whether the rent constitutes reasonable compensation to the nonprofit for the leased hospital's commercial value.⁴²⁰ Because a teaching hospital is hardly a frequently traded asset with a value discernible by looking to an established market, such an assessment will inevitably be subjective and hard to predict, fraught with difficult-to-quantify factors such as the commercial values of a teaching center's current prestige and future potential for medical innovation. The lessor's strongest arguments to the

416. I.R.C. § 501(c)(3) (1988) exempts nonprofit entities "operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes." The set of nonprofits eligible for tax-deductible contributions under I.R.C. § 170 is approximately coextensive with section 501(c)(3).

417. As Henry Hansmann has observed, "repeated and unreflective reinterpretation" of the language of I.R.C. § 501(c) "to accommodate new forms of nonprofit activity . . . has kept the scope of the exemption roughly congruent with the outlines of the nonprofit sector as a whole." Henry Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 YALE L.J. 54, 57-58 (1981). Thus a nonprofit firm, having unburdened itself of its hospital operations, has virtually unlimited freedom to pursue purposes of its choosing without endangering its federal tax exemption, so long as it adheres to section 501(c) proscriptions against "propaganda," lobbying, political campaigning, or inurement of net earnings to private interests.

418. See *supra* note 19 and accompanying text (independent owners of university-affiliated nonprofit hospitals weigh selling their hospitals and using the proceeds to create foundations for the support of health-related activities).

419. I.R.C. § 501(c)(3) (1988) ("No part of the net earnings" of an exempt organization "inures to the benefit of any private shareholder or individual . . .").

420. See, e.g., *Boman v. Commissioner*, 240 F.2d 767 (8th Cir. 1957) (Earnings of a nonprofit clinic were found not to inure to private interests where a partnership of practicing physicians paid an adequate rent for the lease of the clinic's building and equipment.).

IRS on this issue will probably be (1) the arm's-length nature of negotiations leading to such agreements and (2) the lessor's obvious incentive to negotiate the best deal possible.

Even if the lessor can preserve its exempt status, its income from a leasing arrangement will be taxable as "unrelated business income"⁴²¹ unless it can persuade the IRS that the leasing agreement is "substantially related" to the furtherance of its exempt purposes.⁴²² The "unrelated business" income tax applies even to state universities.⁴²³ The Treasury Department has construed the statutory "substantially related" test to require a "causal relationship," aside from the generation of income, between a non-profit firm's "trade or business" activities and its advancement of exempt purposes.⁴²⁴ This approach, which hardly draws a bright line between taxable and exempt leasing income, may yield varying, sometimes unpredictable results for different leasing arrangements.

For example, if the lessor is a fraternal body without other health care programs, it will probably have difficulty convincing the IRS that leasing its hospital to a for-profit firm bears a causal relationship to furtherance of its purposes. If, on the other hand, the lessor is a university that conducts medical teaching and research activities in the leased hospital, it should be able to make a strong case for a causal relationship between its hospital business and its educational and scientific purposes.

421. See I.R.C. § 511 (1991) (Unrelated business income of exempt organizations is taxable).

422. See I.R.C. § 513 (West 1991) (defining an unrelated business as "any trade or business the conduct of which is not substantially related (aside from the need of [an exempt organization] for income or funds or the use it makes of the profits derived) to the exercise or performance by such organization of its charitable, educational, or other [exempt] purpose or function."). The regulations implementing this provision establish a three-part formula for determining whether a particular income stream is taxable: (1) the income must come from a "trade or business," Treas. Reg. § 1.513-1(b) (as amended in 1983); (2) the trade or business must be "regularly carried on," as evinced by "frequency and continuity" and a manner "generally similar to comparable commercial activities of non-exempt organizations," Treas. Reg. § 1.513-1(c) (as amended in 1983); and (3) activity of the trade or business must not be "substantially related" to the organization's exempt function(s), Treas. Reg. § 1.513-1(d)(1) (as amended in 1983).

Long-term leasing of real property satisfies the first and second parts of this test: it qualifies as a "trade or business" that is "regularly carried on." Therefore, whether a nonprofit organization's earnings from the lease of its hospital to a for-profit firm qualify as "unrelated business income" hinges on whether the lease arrangement is "substantially related" to the nonprofit's exempt purposes.

423. See I.R.C. § 511 (1991).

424. Treas. Reg. § 1.513-1(d)(2) (as amended in 1983) (stating that activity is "substantially related" if it "contributes importantly" to an exempt purpose). Thus, for example, a nonprofit hospital's leasing of an adjacent building to its staff physicians for use as office space for seeing private patients was held to be a *related* business where the lessees provided all clinical care at the hospital. Rev. Rul. 69-463, 1969-2 C.B. 131.

An independent nonprofit firm that leases out its university-affiliated hospital and then uses the proceeds to support other health-related activities may find itself in an ambiguous position with respect to the "substantially related" requirement. The IRS's position will depend on an individualized assessment of the leased hospital's role in the nonprofit's other health-related work.

Once a for-profit firm buys or leases a teaching hospital, research and teaching activities conducted at the hospital by a nonprofit institution will have to satisfy the statutory proscription against inurement of "net earnings" to private interests.⁴²⁵ In evaluating an affiliation arrangement between a university and a for-profit teaching hospital, the IRS is likely to focus on whether (1) the for-profit firm is deriving any benefit from the university for less than commercially reasonable compensation, and (2) the governance mechanisms for university programs at the hospital create incentives and opportunities for distribution of program benefits—beyond those contracted for at reasonable fees—to the for-profit firm.⁴²⁶

Thus, the university should make sure that services provided by the hospital to support academic activities, as well as services made available to the hospital by the university,⁴²⁷ are contracted for at arm's length and compensated at commercially reasonable levels. Moreover, the university ought to insist on governance mechanisms that insure its control over the administration of academic activities at the hospital.⁴²⁸ Individuals with academic positions at the university probably should not also hold hospital appointments as officers or employees, and no hospital officer or employee should exercise budgetary or policy-making authority

425. See I.R.C. § 501(c)(3) (1991).

426. No published IRS or court decisions apply the proscription against private benefit to universities affiliated with for-profit hospitals. However, management contracts between nonprofit hospitals and for-profit firms provide a plausible, albeit imperfect analogy to such affiliations. To satisfy the proscription against private benefit, a nonprofit hospital that contracts with a for-profit firm for management services must ensure that the contract is negotiated at arm's length and that its own governing board retains ultimate control over matters of policy. Moreover, the manager's compensation must not depend on the hospital's earnings; otherwise the IRS may view the contract as a device for distributing profits to the manager. 5 HOSPITAL CONTRACTS MANUAL 41-42.

The principle underlying these restrictions seeks to assure not only that "net earnings" (benefits in excess of reasonable compensation for goods or services) are not *actually* distributed, but also that contractual arrangements between for-profit and nonprofit firms preclude even the *potential* for distribution of net earnings to a for-profit firm. This potential could take the form of a conflict of interest at the negotiating stage, control by agents of a for-profit firm over policy-making aspects of a nonprofit's operations, or opportunities and incentives built into the contract.

427. For example, unusual or experimental clinical tests performed in academic laboratories.

428. In practice, the intermingling of patient care, clinical research, and teaching in academic medical centers makes it exceedingly difficult to draw clear lines between clinical and academic

over a university program. These restrictions could occasionally make collaboration between the hospital and the university's teaching and research programs cumbersome. But they may provide the university with added protection against exploitative behavior by a for-profit firm after a sale or lease takes effect.

2. Property Tax

Property tax liability is another important consideration for all parties to the sale or lease of a teaching hospital to a for-profit firm. Sale to a for-profit firm, of course, terminates a hospital's property tax exemption, rendering the for-profit liable for state and local levies on the facility's real property.⁴²⁹ The property tax consequences of a leasing arrangement are less clear-cut. So long as the nonprofit lessor, after ceasing its involvement in hospital operations, maintains another accepted charitable or educational purpose, it will continue to qualify, as an organization, for property tax exemption. However, property owned by an exempt entity and leased, for a commercial rate, to a nonexempt organization is generally taxable.⁴³⁰

programs. Many clinical services are provided by trainees who learn by doing, and research protocols draw their subjects from the hospital's patient base. Lines of hospital and university administrative authority are thereby so intertwined that to entirely eliminate hospital management's influence from the administration of hospital-based academic programs would be impossible.

What sort of line the IRS might attempt to draw between acceptable indirect leverage (e.g., hypothetically, some role in decisions about the number and salaries of interns and residents) and intolerable influence (e.g., hypothetically, power to exert pressure on faculty or trainees to change patterns of clinical practice that affect a hospital's revenues) is not possible to predict. But in negotiating agreements with for-profit firms, universities can use this uncertainty to strengthen their hand on issues of hospital versus university control over operational matters.

429. See WARREN, *supra* note 412, at 304. By selling its hospital, a nonprofit organization does not jeopardize the exempt status of its other properties, so long as (1) it continues to qualify for exemptions by virtue of its other charitable or educational purposes, and (2) the other properties meet the requirement, extant in most jurisdictions, that their use be reasonably necessary for the organization's charitable or educational work. *Id.* at 305, 307.

430. HEALTH LAW CENTER, THE HOSPITAL LAW MANUAL Taxation ¶ 3-3 (1982). Determination of whether a particular property is exempt involves a two-step process. First, the owner of the property must qualify for exemption by virtue of its purposes and form of organization. Second, the property itself must meet a state's criteria for "ownership" by the exempt entity and "exclusive use" for exempt purposes. *Id.* at ¶¶ 3-1, 3-2. The "exclusive use" requirement, usually the key factor in an exemption determination, varies widely in application among the states. *Id.* at ¶ 3-2. But in most states, this requirement is considered to be met by a showing that a property's use is "reasonably necessary" to further the owner's exempt purpose or purposes. WARREN, *supra* note 412, at 307. The property itself, not the income it produces, must survive "exclusive use" scrutiny. Thus, in general, property used commercially is not exempt. EDITH L. FISCH, DORIS J. FREED & ESTHER R. SCHACTER, CHARITIES AND CHARITABLE FOUNDATIONS 616-17 (1974) [hereinafter CHARITIES].

In some states, rent or income producing property is automatically barred by statute from exemption.⁴³¹ In these states, the lease of a hospital to a for-profit firm would unavoidably subject the nonprofit lessor to state and local levies on the property. But in most states, income producing property can retain its exemption upon a showing that use of the property itself (as opposed to the income it generates) is "reasonably necessary" to advance the owner's exempt purposes.⁴³² Thus, for example, office space rented out to private physicians by nonprofit hospitals has occasionally been found exempt on the ground that the physical presence of staff doctors in or near the hospital for most of the working day facilitates quality inpatient care.⁴³³

A university that leased its teaching hospital to a for-profit firm would be well positioned to argue that this use, albeit unconventional, is "reasonably necessary" for education and research. If a state or municipality were to challenge the leased facility's exemption, the university could (1) explain the essential role of teaching hospitals in medical training and research, and (2) cite the financial hazards and demands of hospital operation⁴³⁴ as sound reasons for turning over its teaching hospital to a private firm. This line of reasoning ought to suffice to defeat a challenge.

Nonuniversity lessors, however, would be in weaker position. A nonprofit entity—for example, a fraternal body—without other health-related programs would probably not be able to make a convincing showing that teaching hospital lessorship is "reasonably necessary" to achieve its exempt aims. Even a nonprofit with other health programs might find its position problematic, depending on the nexus between these programs and operation of a teaching hospital. Determination of a leased hospital's eligibility for property tax exemption will depend on an individualized assessment of the facility's importance to the nonprofit's other

431. CHARITIES, *supra* note 430, at 617.

432. *See supra* note 430.

433. WARREN, *supra* note 412, at 308. Likewise, hospital property rented out as housing for hospital employees or used for cafeterias, gift shops, or pharmacies is frequently found exempt on the ground that these uses further the hospital's "charitable" purpose and only "incidentally" produce income. *Id.* at 309-10. *But cf.* Julia L. Butterfield Memorial Hosp. Ass'n v. Town of Philipstown, 368 N.Y.S. 2d 852 (1975) (holding that hospital property rented to physicians who use the property exclusively for their own private gain is not exempt from taxation).

434. *See supra* text accompanying notes 91-119.

exempt activities.⁴³⁵ The outcome may in some cases be difficult to predict.

C. DONORS' RESTRICTIONS ON CHARITABLE GIFTS

Though private philanthropy today supports a shrinking proportion of the operating budgets of academic medical centers, major teaching hospitals and medical schools typically hold millions of dollars in gifts, bequests, and other donated resources. Myriad restrictions imposed by donors govern the use of these holdings. The purchase or lease of teaching hospitals by for-profit firms, and medical schools' affiliations with these hospitals subsequent to such transactions, may come into conflict with some of these restrictions.⁴³⁶ I will briefly consider here the kinds of conflicts that could result, the potential legal consequences of violating such restrictions, and the legal and other options available to administrators of medical schools or other nonprofit entities facing possible violations.

1. *Potential Violations Resulting From the Purchase or Leasing of Teaching Hospitals by For-Profit Firms*

The extraordinary range of restrictions imposed by charitable donors defies any attempt to characterize them summarily. Typical limitations include requirements that a gift be applied to the construction or purchase of some physical asset (such as a hospital or laboratory building or some novel clinical or research instrument) or to support a particular clinical, research, or educational activity. Also common are institutional qualifications for the use of a gift (for example, the user must be a hospital that is owned or operated by a particular nonprofit organization). The possibilities are as limitless as the spectrum of human idiosyncrasy. Trustees and officers of nonprofits that hold charitable contributions have a common law duty to comply with donors' restrictions.⁴³⁷

For the purpose of analyzing potential conflicts between such restrictions and for-profit ownership or leasing of teaching hospitals,

435. The problem is akin to determining whether a nonprofit's income from a leasing arrangement is subject to the federal tax on exempt organizations' "unrelated business income." See *supra* text accompanying notes 421-25.

436. Purchase and leasing arrangements, as well as the for-profit teaching hospital's subsequent affiliation with a medical school, may also violate the terms of an affected nonprofit organization's charter or certificate of incorporation. However, this should in general pose little difficulty because in most states a nonprofit organization has statutory authority to modify its charter or certificate of incorporation. CHARITIES, *supra* note 430, at 406.

437. *Id.* at 402.

assets donated to nonprofit teaching hospitals and medical schools may be separated into three broad groupings. These categories are based on changes in asset application that would accompany a teaching hospital's shift to for-profit operation. They are as follows: (a) physical assets (land, plant, and equipment) held by a hospital; (b) hospital endowment funds (used to support of various hospital activities); and (c) medical school endowment funds used to support teaching and research activities conducted at or in conjunction with the hospital. I will consider how the application of assets in each of these groupings would be changed by the sale or lease of a teaching hospital to a for-profit firm and how these changes might violate some typical donors' restrictions on the use of these assets.

a. *Physical assets held by teaching hospitals:* Purchase of a teaching hospital by a for-profit firm would in effect convert donated resources originally dedicated to physical assets into an endowment corpus available to the seller for other uses.⁴³⁸ For universities and other nonprofits that wish to promote medical education and research but are wary of the risks and burdens of teaching hospital ownership, such a conversion may be intensely attractive. Managers of a nonprofit organization are, in general, empowered to sell its real and personal property for adequate consideration⁴³⁹ if the sale plausibly furthers the organization's purposes.⁴⁴⁰ This power, however, is subject to donors' restrictions.⁴⁴¹ The requirement, for example, that a donated parcel of land occupied by the hospital not be sold would stand in the way of a sale to a for-profit firm. So would a proviso that a gift used by a hospital's management to acquire some physical asset be employed only for the actual operation of a hospital by

438. The seller, such as a university or a separate nonprofit entity with interests in the health field, might wish to apply income or principal from this corpus toward the support of clinical, educational, or research activities. See, e.g., *supra* note 19 and accompanying text (Independent, nonprofit owners of university-affiliated hospitals are considering selling their hospital operations and using the proceeds to establish foundations for the support of health services, education, and research.). Some sellers might wish to preserve the sale proceeds (and perhaps a proportion of the subsequent income from these proceeds) for possible exercise of a "buy-back" option built into the sale agreement.

439. See, e.g., *New York Medical College v. Dieffenbach*, 211 N.Y.S. 799 (1925).

440. See, e.g., *Bennett v. Attorney Gen.*, 96 S.E.2d 46 (N.C. 1957) (holding that the trustee of a will may rent or sell property if impractical to maintain); *Bossen v. Woman's Christian Nat'l Library Ass'n*, 225 S.W.2d 336 (Ark. 1949) (holding that a trustee of a charitable trust may sell trust property unless expressly forbidden).

441. See *Hendrix College v. Arkansas Townsite Co.*, 108 S.W. 514 (Ark. 1908). Nonprofit managers must observe restrictions imposed by donors of either the property itself or the funds used to acquire (or construct) it.

the donee. Even if only a small proportion of a nonprofit hospital's physical assets were acquired through charitable gifts subject to such restrictions, these limitations could pose serious legal barriers to a sale⁴⁴² unless the would-be seller could find some way to circumvent them.

The lease of a teaching hospital to a for-profit firm would not alter the *form* of donated resources originally dedicated to physical assets—they would remain invested in real and personal property owned by the donee. A lease, however, would change the *use* of these assets, from support for hospital operations to generation of a *revenue stream* (leasing fees) for the support of other activities. Managers of a nonprofit entity are generally empowered to lease real and personal property unless specifically proscribed from doing so in the instrument conveying either the property⁴⁴³ or the resources used to acquire the property. Thus a proviso that donated real property not be sold or that a cash contribution be used only to build or acquire some physical asset would pose no obstacle to leasing a hospital unless the donative instrument also explicitly barred leasing. However, if a donor imposed a condition that the donee may employ a gift of physical assets, or of funds to be used for the acquisition of physical assets, only for the support of its own, nonprofit hospital operations, a leasing arrangement would clearly violate the condition.

b. *Hospital endowment funds:* Sale or lease of a teaching hospital to a for-profit corporation would leave donated hospital endowment funds in the hands of the seller, lessor, or a successor nonprofit entity (such as a foundation⁴⁴⁴). No longer necessary for the support of hospital operations, these funds could be applied, within the limits imposed by donors' restrictions, to the support of other clinical, teaching, or research activities. Thus, for example, income from a gift subject only to the requirement that the donee apply it toward clinical training or research within a particular subspecialty could be used to provide grants for training or research to academic institutions or faculty members. However, a gift restricted by the proviso that it be applied only to support some activity at a donee-operated hospital could not be expended except in violation of the donor's conditions.

442. Violation of these restrictions would constitute a breach of duty on the part of the seller's trustees, exposing them to possible enforcement actions by the state attorney general. See *infra* text accompanying notes 449-64.

443. See, e.g., *Merchants Bank & Trust Co. v. New Canaan Historical Soc'y*, 54 A.2d 696 (Conn. 1947). But cf. N.Y. NOT-FOR-PROFIT CORP. LAW § 510 (McKinney 1986) (requiring court approval of the lease of all or substantially all assets of a charitable corporation).

444. See *supra* note 19 and accompanying text.

In contrast to donors' restrictions on the disposition of gifts of or for physical assets (which could pose legal barriers to a sale or lease⁴⁴⁵), donors' limits on the use of endowment funds could not, in themselves, erect a legal impediment to a sale or lease. But these limits could render such funds legally unavailable to the donee once it executes a sale or lease, unless the donee were able to devise a legal strategy to avoid them.

c. *Medical school endowment funds*: The purchase or lease of a teaching hospital by a for-profit firm would not affect the ownership of medical school endowment funds used to support teaching and research activities conducted at or in conjunction with the hospital.⁴⁴⁶ Nor would it change their application, except in the sense that monies paid to the hospital for space and for clinical and support services⁴⁴⁷ would accrue as income to a for-profit enterprise. This change should pose no obstacle to continued use of donated funds to support academic programs at or in conjunction with the hospital, unless conditions attached to a particular gift proscribe its use within a for-profit hospital setting.⁴⁴⁸

2. *Enforcement of Donors' Restrictions*

Only the state attorney general, as a rule, can initiate legal action against the managers of a nonprofit organization to enjoin or redress the violation of a donor's restrictions on the use of a charitable gift.⁴⁴⁹ The

445. See *supra* text accompanying notes 438-44.

446. The analysis for medical school endowment funds applies also to donated funds held by private research institutes or other separate entities that conduct academic activities at or in conjunction with a for-profit teaching hospital.

447. See, e.g., clinical laboratory tests for patients admitted to the hospital as part of a medical school research protocol.

448. However, the use of donated funds to purchase space or services from a for-profit hospital could subject the medical school's managers to closer judicial scrutiny for violations of their duty to administer charitable gifts faithfully, and not for the benefit of other interests. Medical school managers, in theory, are bound by this duty even when conducting affairs with other charitable corporations, including affiliated, nonprofit teaching hospitals. See *Conway v. Emeny*, 96 A.2d 221 (Conn. 1953) (holding that charitable trustees may not act in manner that furthers interests of contingent beneficiary under donor's will even if the beneficiary is another charitable organization). But when a medical school engages in transactions with a for-profit teaching hospital administered by a semi-autonomous local governing board that includes medical school representatives (see *supra* text accompanying notes 381-86 and *infra* text accompanying notes 530-35), the potential antagonism of interests may invite closer judicial examination. Cf. *Stern v. Lucy Webb Hayes Nat'l Training Sch.*, 381 F. Supp. 1003, 1014 (D.D.C. 1974) (Charitable managers may deposit the charity's funds in a bank having an interlocking directorate with the charity, but "such transactions will be subjected to the closest scrutiny to determine whether or not the duty of loyalty has been violated.").

449. CHARITIES, *supra* note 430, at 553, 554-556 (The attorney general's enforcement power is derived either from common law or statute.). There are some infrequent exceptions to this rule: charitable trustees and directors may bring suit against co-trustees and co-directors to enjoin or

attorney general may act either on his or her own initiative or upon a complaint from a third party—typically a donor, or heir, or a would-be beneficiary, though the complaining party need not have a special interest in the matter.⁴⁵⁰ Donors and their heirs, in general, may neither initiate nor intervene in such an enforcement proceeding; their role is limited to that of a complainant, or “relator,” in an action begun by the attorney general.⁴⁵¹ With few exceptions, the same applies to potential beneficiaries.⁴⁵² The attorney general, moreover, has virtually unreviewable discretion to initiate or withhold enforcement action.⁴⁵³ In practice, action by state attorneys general has been exceedingly rare.⁴⁵⁴ Observers have attributed this to resource constraints and the low political appeal of aggressive enforcement of law governing management of charities.⁴⁵⁵

However, the specter of a teaching hospital’s conversion to for-profit operation invites public attention, which could kindle a new enforcement activism among state attorneys general. Because he or she must be sensitive to public perceptions of academic medical centers as vital community resources (and to doubts about the propriety of for-profit hospitals),

redress breaches of trust, and successor trustees may bring similar actions against predecessor trustees. Directors of a charitable corporation, moreover, may institute a stockholder’s derivative suit against the corporation. *Id.* at 560-61. Even more rarely, individuals or institutions clearly designated as beneficiaries in a gift’s governing instrument or by the managers of a charitable entity may bring an action to compel receipt of benefits. *See id.* at 562. These exceptions, however, are unlikely to come into play for the transactions discussed herein, so long as trustees and directors of the involved hospitals, universities, or other nonprofit entities forge a consensus before taking any action that could conceivably involve a breach of duty.

450. *Id.* at 556.

451. *Id.* at 559. The usual rationale for this rule is that once a gift has been made, the donor possesses neither legal nor equitable title—only a sentimental interest, not sufficient to confer standing to sue or intervene. However, a tiny minority of jurisdictions do permit the donor or the donor’s heirs to bring an enforcement action. Moreover, if a gift instrument reserves the power to revoke or modify the disposition, a donor or heir may sue for damages or recovery. *Id.* at 559-60.

452. *Id.* at 563-64. The much-disparaged rationale for denying potential beneficiaries standing to sue is that their interest is represented by the attorney general. *Id.* at 564, 569 (criticizing this reasoning on the ground that “the attorney general represents the public interest in a charity and not necessarily the interests of any particular class of potential . . . beneficiaries”).

453. *Id.* at 557-58. Except for a statutory requirement that the attorney general bring suit if certain conditions are met, e.g., FLA. STAT. ANN. § 617.09 (West 1977) (attorney general must initiate suit upon complaint of any citizen or member of a charitable corporation who comes forward with prima facie proof of his allegation and enough money to cover litigation expenses), judicial review of the attorney general’s decision not to commence an action has been held to violate the constitutional separation of powers. *Ames v. Attorney Gen.*, 124 N.E.2d 511, 513 (Mass. 1955).

454. CHARITIES, *supra* note 430, at 567-68.

455. *Id.* at 566-69 (citing insufficient staff, appropriations, and available data on charities, as well as reluctance of state officials to pursue allegations that respected institutions and individuals are in breach of their duties).

an attorney general who is aware of an impending sale or leasing arrangement might rummage through the moribund law of charitable gift enforcement in search of some way to block a deal.

The enforcement remedies⁴⁵⁶ available to an attorney general vary widely, depending upon the peculiarities of each case. Where a sale or lease itself would allegedly violate some restriction on the use of donated property,⁴⁵⁷ the attorney general can ask the court for an injunction proscribing the sale or lease—or even rescinding it if it has already been executed.⁴⁵⁸ If unable to block a deal in this manner, the attorney general might still be able to apply indirect leverage by identifying restrictions on the use of donated funds that arguably render them legally unavailable to the donee once the sale or lease takes effect,⁴⁵⁹ then asking the court to enjoin the donee's use of these funds in the event of a sale or lease.⁴⁶⁰ After a violation of a restriction has already occurred, the attorney general, in theory, could also petition the court for removal of the responsible trustees, directors, or corporate officers.⁴⁶¹ This drastic remedy, however, appears to have been ordered only in cases of nonfeasance or malfeasance with the potential to result in loss of charitable property.⁴⁶²

3. *Alternatives for Coping with Donors' Restrictions*

If a donor's restriction appears to pose an obstacle to the sale or lease of a teaching hospital to a for-profit firm—or to the use of endowment funds after a sale or lease takes effect—two general approaches are open to the donee's managers. They could adopt an activist, litigation-

456. Absent a proviso in the gift instrument calling for forfeiture if the donor's restrictions are violated, such a breach of trust is not grounds for judicial termination of a gift. The proper (and only) legal remedy is enforcement of the gift's terms. *Id.* at 505-506. The only exceptions to this rule have been occasioned by inter vivos dispositions, which have sometimes been judicially returned to the original donor upon violation of the donor's restrictions. *Id.* at 506-507.

457. *E.g.*, a requirement that a donated parcel of land occupied by the hospital not be sold would proscribe its purchase by a for-profit. *See supra* text accompanying notes 441-42.

458. *See CHARITIES, supra* note 430, at 549 (available enforcement remedies include enjoining wrongful conduct and rescinding transfers of property).

459. *See supra* text accompanying notes 446-48.

460. The attorney general could exercise similar leverage by merely making it known to would-be sellers or lessors that it might file suit against the donee after execution of a sale or lease to enjoin use of these funds or, if they have already been improperly applied, to compel the donee to replenish them.

461. *See CHARITIES, supra* note 430, at 550-53 (summarizing grounds for judicial removal of directors, trustees, and officers).

462. *Id.* at 552 (stating that to justify removal, lack of managerial capacity or fidelity must imperil ownership of the charitable property); *cf. e.g.*, *Attorney Gen. v. Olson*, 191 N.E.2d 132 (Mass. 1963) (overturning lower court's removal ordered for failure to file annual accounting).

oriented strategy, petitioning the courts for permission to violate the restriction. Courts may grant such permission in certain circumstances under the equitable doctrines of "deviation" and "cy pres."⁴⁶³ Alternatively, the donee's managers could opt for a "low profile" strategy, quietly taking steps that might violate the donor's conditions and gambling that the attorney general's disinclination to aggressively superintend restrictions on charitable gifts⁴⁶⁴ will suffice to avert an enforcement action. During the planning process preceding a sale or lease agreement, they could informally consult with the attorney general, exploring areas of concern, adapting their plans accordingly, and negotiating for commitments not to bring potential enforcement actions.

a. *The activist strategy: "Deviation" and "cy pres":* The equitable doctrines of deviation and cy pres empower courts to permit the use of donated resources in ways that depart from donors' restrictions. Though these doctrines overlap broadly in their application, each has different prerequisites. In practice, the prerequisites for deviation are more easily met, making it a more flexible doctrinal tool than cy pres for countenancing violations of donors' conditions. But the vaguely stated prerequisites for both deviation and cy pres relief allow ample room for result-oriented rulings on whether particular sets of facts warrant the application of either doctrine. Jurisdictions vary widely in their application of these doctrines.

i. *Deviation:* The doctrine of deviation allows courts to authorize the breach of an "administrative" restriction on a charitable disposition upon a finding that either (1) compliance with the restriction is "impossible or illegal"; or (2) owing to "circumstances not known or foreseen" by the donor, compliance "would defeat or substantially impair the accomplishment of the intended . . . purpose" of the gift.⁴⁶⁵

463. The state attorney general may also, as a rule, institute a cy pres application for court permission to violate a donor's restriction. CHARITIES, *supra* note 430, at 458-60. If the attorney general is amenable, commencement of an action by the donor—either alone or conjointly with the donee—might in some cases give the request a greater aura of legitimacy than would initiation of action by the donee alone.

A cy pres petition typically takes the form of a request that the court apply the doctrine in accordance with a contract entered into by a nonprofit organization for sale or lease of assets. Prospective cy pres beneficiaries wishing to contest the disposition requested by the donee or the attorney general may intervene in the proceedings at the court's discretion. However, they have no standing either to initiate a cy pres action or to intervene as a matter of right, and courts are generally reluctant to permit their intervention. Only charitable trustees or directors or the attorney general may commence a cy pres proceeding. *Id.* at 458-60, 462.

464. See *supra* text accompanying notes 453-56.

465. 15 AM. JUR. 20 *Charities* § 164 (1976).

Thus, where a restriction can be plausibly characterized as "administrative," deviation gives the courts sweeping power to permit donees to ignore it. In recent decades, courts have applied the doctrine with increasing liberality to circumvent restrictions that impede the efficient use of donated resources.⁴⁶⁶

In a 1966 Connecticut case, for example, the deed of trust for a parcel of land occupied by a nonprofit hospital required that the land be used "for no other purpose whatsoever" than as the site of a general hospital or a nursing school. The hospital obtained a declaratory judgment allowing it to erect and operate a doctors' office building on this land. Observing that nonprofit hospitals typically rent private office space to medical staff, the court stated that "reasonable deviations" were necessary "to keep pace with changes in recognized concepts of the proper sphere of general hospital operations." The building, the court concluded, would "aid plaintiff in more efficiently carrying out" the gift's purpose—the operation of a hospital.⁴⁶⁷ In a 1965 Ohio case, a college was allowed to transfer land and other assets to a state university and to convert itself into a foundation for the support of educational, literary, scientific, and other charitable activities. The court reasoned that these changes were administrative—and thus allowable under the doctrine of deviation—because they enhanced the educational effectiveness of resources donated for the purpose of advancing education without materially altering the donors' charitable aims.⁴⁶⁸

In short, if a court is willing to characterize a donor's condition as delimiting means (administration) rather than ends (charitable purpose),⁴⁶⁹ deviation permits a nonprofit hospital to justify waiver of the restriction by invoking efficiency arguments. Thus, arguments drawing on the economic changes that have prompted teaching hospital owners to consider selling or leasing hospital operations and finding other means to advance medical research and teaching⁴⁷⁰ are likely to be received favorably in deviation proceedings.

466. CHARITIES, *supra* note 430, at 407.

467. *Charlotte Hungerford Hosp. v. Mulvey*, 225 A.2d 495 (Conn. 1966).

468. *Fenn College v. Nance*, 210 N.E.2d 418 (Ohio 1965).

469. Other stipulations in a gift instrument may limit a court's flexibility to characterize a restriction as merely administrative. These include provisos for reverter or for an alternative disposition in the event that the donee violates the restriction. CHARITIES, *supra* note 430, at 409-10. Such provisions in effect establish compliance with the restriction at issue as an essential element in the gift's purpose.

470. *See supra* text accompanying notes 91-158.

In a petition for deviation from a restriction that would bar a sale or lease, courts should give considerable weight to the argument that intensified competitive pressures in the hospital industry are "circumstances not . . . foreseen" by a donor and would render a gift more effective in advancing medical research or teaching if applied to some activity other than hospital operations. For example, a proscription against the sale of donated land occupied by a teaching hospital should not, as a rule, survive an action for deviation brought by the donee (and supported by economic arguments) in anticipation of the hospital's purchase by a for-profit firm.⁴⁷¹ Similarly, a proviso that donated property be used by the donee only for hospital operations should not survive a deviation petition brought to clear the way for a sale or lease and for use of the proceeds in an alternate manner.

Donors' restrictions that render endowment funds unavailable for use after a sale or lease has taken effect⁴⁷² should be easily modifiable through application for deviation so long as the court characterizes them as administrative. Compliance with such restrictions is obviously impossible or illegal, and deviation is therefore appropriate to save these funds.

ii. Cy pres: The requirements for approval of an application for cy pres relief are, in practice, considerably more restrictive than for deviation. Technically, cy pres, unlike deviation, permits the use of a gift for a purpose *different* from, albeit "as near as possible to," the "precise objective of the donor."⁴⁷³ But to invoke cy pres, a court must make two findings: (1) that it is "impossible, impractical, or illegal" to effect the donor's "precise objective,"⁴⁷⁴ and (2) that, in addition to his precise objective, the donor evinced a "general charitable intent extending beyond the specific one which is impossible, impractical, or illegal."⁴⁷⁵ Deviation doctrine enables a court to circumvent the prerequisite of general charitable intent by characterizing a restriction as merely administrative, that is, without bearing on "purpose."⁴⁷⁶ Moreover, deviation

471. In many situations, courts have applied the doctrine of deviation to permit the sale of charitable realty in breach of donors' restrictions. CHARITIES, *supra* note 430, at 408-409 (citing numerous cases presenting a wide range of circumstances). Strictly speaking, court authorization of the sale of charitable realty and the use of sale proceeds for something other than the purchase of an alternate site may be more properly cognizable as an application of the doctrine of cy pres. But in practice, many courts have preferred to take such action under the less restrictive rubric of deviation. *Id.* at 410-12.

472. See *supra* text accompanying notes 444-48.

473. CHARITIES, *supra* note 430, at 414.

474. *Id.* at 413-14, 434-37, 442-45.

475. *Id.* at 437-42.

476. *Id.* at 411-12.

allows more room for efficiency-oriented arguments against the survival of restrictions by providing for relief in circumstances where, owing to circumstances unforeseen by the donor, compliance with a restriction would "substantially impair" accomplishment of a gift's purpose.⁴⁷⁷

The cy pres requirement of impossibility, impracticality, or illegality has been construed with varying degrees of restrictiveness. Before the turn of the century, strict deference to the donor's wishes led courts to reject cy pres applications without regard for welfare-maximizing considerations, so long as the donor's original design could be carried out.⁴⁷⁸ More recently, most jurisdictions have evinced a willingness to take social utility into account in assessing donors' restrictions for impracticality.⁴⁷⁹ The role of social utility considerations in determining impracticality is at present ill defined. But the impossibility, impracticality, or illegality prerequisite has not yet evolved into a frank utility-maximization standard.

Thus, in their effort to prove impracticality, would-be sellers or lessors of teaching hospitals could cite mounting economic pressures and argue that they can best foster medical research and education by reapplying their assets to other activities. However such reasoning is, in general, likely to carry less weight than it would under deviation doctrine.⁴⁸⁰ Where failure to allow a sale or lease could trigger an impending financial crisis—for example, bankruptcy or large-scale diversion of funds from other valued programs to meet a hospital's operating deficit—and lead to gross squandering of resources, evidence of the economic wastefulness of the restriction at issue should prove decisive.⁴⁸¹ But where no immediate crisis looms—where a sale or lease is not necessary to insure the hospital's short-term survival, save it from sharp decline, or preserve other programs endangered by diversions of funds to cover the hospital's deficit—welfare-maximizing rationale is less likely to suffice to prove impracticality.

477. See *supra* text accompanying notes 465-71 (success of efficiency-oriented reasoning in deviation cases).

478. CHARITIES, *supra* note 430, at 443-44.

479. *Id.* at 444 (citing cases importing a concern for social utility into the "impracticality" element of the traditional "impossibility, impracticality, or illegality" prerequisite for cy pres).

480. See *supra* text accompanying notes 465-71 (success of efficiency-oriented arguments in deviation cases).

481. Cf. *In re Neher's Will*, 18 N.E.2d 625 (N.Y. 1939) (Real property donated for use as a hospital was applied by cy pres to another use because a new hospital in a nearby village was believed to serve the region's needs adequately, making the opening of another hospital wasteful.).

Restrictions that render endowment funds unavailable for use after a sale or lease has taken effect⁴⁸² will, on their face, meet the impossibility, impracticality, or illegality prerequisite. But a barrier would arise if a court found that the donee, in executing the sale or lease, created a condition of impossibility, impracticality, or illegality in order to satisfy its own convenience.⁴⁸³

In addition to assessing the impossibility, impracticality, or illegality of a restriction, a court considering a cy pres application must, at least in theory, look carefully for indicia of general charitable intent. Frequently criticized as a thin veil for the arbitrary exercise of judicial discretion, general charitable intent has been defined as "a desire to benefit a charitable purpose or objective rather than any particular object or institution."⁴⁸⁴ Evidence of general intent may be discerned in the gift instrument itself or from surrounding circumstances.⁴⁸⁵

Courts have created no hard-and-fast rules for the identification of general charitable intent, but they have developed guidelines for inference.⁴⁸⁶ General charitable intent is probably lacking where a provision in the donative instrument calls for forfeiture, failure, or reversion if the gift cannot be effected in the specified manner. The absence of such a provision invites more permissive construction. Gifts in perpetuity are usually interpreted as manifesting general intent, even when the donative instrument is quite specific as to application, because courts assume that donors expect changing conditions. Other potential indicia include the character of a testator's other bequests, the donee's avowed purposes and commonly known activities, and even evidence of the donor's personal interests and aspirations.⁴⁸⁷ The judicial inclination to sustain charitable dispositions is so strong that courts sometimes strain the limits of plausible inference to find a general charitable intent.⁴⁸⁸

482. See *supra* text accompanying notes 444-48.

483. Cf. *Connecticut College v. United States*, 276 F.2d 491 (D.C. Cir. 1960) (A gift was made for construction of a memorial building on a particular site at the U.S. Military Academy but the academy contended this site had been reserved for another facility and brought cy pres action for permission to apply gift toward construction of the building on another site; permission was denied on the ground that impossibility had been created by the donee for its own convenience).

484. CHARITIES, *supra* note 430, at 438.

485. See, e.g., *In re Syracuse Univ.*, 148 N.E.2d 671 (N.Y. 1958) (denying cy pres approval for transfer of gift to state university, after the state took over Syracuse University's medical college, where, based on the language of the will and all the known surrounding facts, the testator intended to benefit humanity through the field of medicine but only via Syracuse's medical college).

486. See 15 AM. JUR. 20 *Charities* § 163 (1976) (indicia of intention).

487. *Id.*

488. See, e.g., CHARITIES, *supra* note 430, at 442 (citing cases construing donors' provisions that property be devoted to a particular purpose "forever" or to a designated purpose and no other as

When approving departures from gift restrictions, courts in some jurisdictions have avoided cy pres by characterizing donors' precise objectives in terms sufficiently broad to encompass the modifications. By accordingly conceptualizing departures from donors' restrictions as changes in means rather than shifts in purpose, they have averted the need to apply the cy pres "impossible, impractical, or illegal" standard,⁴⁸⁹ and thereby availed themselves of the greater discretion allowed under the doctrine of deviation.⁴⁹⁰ This creative reinterpretation of the cy pres concept of precise objective collapses the traditional cy pres distinction between precise objective and general charitable intent.

Where courts avoid cy pres by characterizing gift objectives in broad terms so that departures from donors' restrictions can be construed as changes in means,⁴⁹¹ they are unlikely to invoke cy pres to modify restrictions on gifts to medical institutions. For most such gifts, courts ought to be able to discern an intent to advance medical care, research, or education⁴⁹²—an intent inclusive enough to allow modifications through application of the more permissive deviation doctrine.⁴⁹³ But where language in a gift instrument constrains a court to characterize the donor's objective in terms so limiting that a proposed modification would alter the objective⁴⁹⁴—or where courts insist on the traditional cy pres distinction between the donor's precise objective and general charitable intent⁴⁹⁵—application of cy pres doctrine will be determinative for universities and current (or former) teaching hospital owners seeking court permission to breach donors' restrictions.

merely indicating the donor's wish that the gift be used for the designated purpose as long as possible or practical).

489. *Id.* at 445, 467 (giving an example of a gift to a hospital for construction of an operating room; if the gift is too small for this purpose and the hospital wishes to apply it toward construction of additional patient rooms, the court can authorize this without invoking cy pres by finding that donor's purpose was to promote health—a purpose just as well served by building patient rooms).

490. *See supra* text accompanying notes 476-77.

491. *See supra* text accompanying notes 488-90.

492. *See, e.g.,* Bell v. Shannon, 367 S.W.2d 761 (Tenn. 1963) (The donor's objective was said to have been carried out where a bequest to found a new hospital was reapplied by the court, without invocation of cy pres, to construct a new wing for an existing hospital).

493. *See supra* text accompanying notes 465-71 (discussing prerequisites and application of deviation doctrine).

494. For example, the instrument accompanying a gift of land to a fraternal organization might require (1) that the land be used only for operation of a hospital by the organization, and (2) that the land revert to the donor or his estate if it ceases to be used in such a manner. Just as this reverter provision would make it difficult for a court to find the "general charitable intent" required for cy pres, *see supra* text accompanying notes 483-85, the reverter clause would render implausible the conclusion that operation of a hospital by the donee was not essential to the donor's purpose.

495. *See supra* text accompanying notes 476, 484-88.

b. *The "low-profile" strategy:* Faced with donors' restrictions that might proscribe a sale, lease, or the subsequent use of endowment funds, a nonprofit's managers could opt, in the alternative, for a litigation-avoiding, low-profile strategy. The disinclination of state attorneys general to enforce restrictions on charitable gifts—especially gifts to nonprofit entities highly respected in their communities⁴⁹⁶—is an open invitation to managers to act in violation of donors' conditions without first obtaining court authorization. Especially where the dollar value of a restricted gift is small and opposition to the involvement of a for-profit firm is minimal, the likelihood of enforcement action should, in general, be small.

A case in point is the 1984 sale of the Creighton University College of Medicine's primary teaching hospital to American Medical International, Inc. (AMI). Planning for this transaction was complicated by the fact that an unknown amount (thought to be less than one million dollars), which had been contributed in the mid-1970s toward construction of a new hospital complex, had been pledged by its donors to the independent, nonprofit corporation that owned the hospital.⁴⁹⁷ These funds represented only a fraction of the total contributed to a capital campaign conducted jointly by the corporation and Creighton University; the balance had been pledged to the university.⁴⁹⁸ Funds contributed to Creighton and applied toward the new hospital complex were loaned by the university to the corporation, which was the sole owner of the hospital.

This loan arrangement posed no obstacle to AMI's purchase of the hospital a decade later; AMI simply supplanted the seller as Creighton's debtor. But the amount pledged *to the corporation* was more problematic. It was believed that because these funds had been pledged for construction purposes, the proportion of hospital assets representing this corpus could not be included in the sale and then applied (with other sale proceeds) to endow the foundation that was to succeed the hospital.

496. See *supra* notes 454-55 and accompanying text.

497. Telephone interview, on condition of anonymity, with a former official of the Creighton-Omaha Regional Healthcare Corporation, which owned the hospital before the deal with AMI (Nov. 1986).

498. *Id.* According to this source, records of whether funds contributed during this campaign had been pledged to the university or to the independent corporation owning the hospital were not kept by the individual who administered the campaign.

Rather than apply to a court for a deviation or cy pres remedy, corporation and university managers decided to treat these funds as contributions to *Creighton*, subsequently *loaned* to the corporation.⁴⁹⁹ After the sale, AMI assumed this liability. The arrangement clearly violated the pledge conditions.⁵⁰⁰ But the public did not object, and the state attorney general did not bring an enforcement action.

The relatively small sum of money involved and the placid attitude of donors, the public, political leaders, and the medical center community toward AMI's purchase of the hospital facilitated this approach in the *Creighton* example. But where some members of these constituencies actively oppose a sale or lease, violating restrictions without first obtaining court approval could become problematic. Influential opponents could bring pressure to bear on the attorney general, either privately or through public activism. However reluctant to intervene, an attorney general might feel compelled to bring an enforcement action in order to avoid appearing to sanction a breach of trust. To minimize the likelihood of enforcement proceedings, a nonprofit faced with donors' conditions that could stand in the way of a sale or lease should consult informally with the attorney general's office during the planning process preceding a sale or lease agreement.⁵⁰¹

If they are uncertain about whether a restriction bars a sale, lease, or subsequent use of donated funds, managers of institutions with an educational mission should, in general, take a broad view of their *lawful* discretion to act without first obtaining court approval. A leading case in this area suggests that if a donor's conditions can be construed with even strained plausibility to permit a particular measure, the measure is within the scope of managers' lawful discretion if it furthers an educational institution's *overall* welfare. In *Attorney General v. President of Harvard College*, the Massachusetts Supreme Judicial Court held that Harvard's decision to relocate a botany research facility to its Cambridge campus

499. *Id.* This was facilitated by the lack of pledge records. See *supra* note 498.

500. This was privately acknowledged by corporation and university officials. *Id.*

501. In such consultations, the nonprofit's representatives could sound out the attorney general's position on troublesome restrictions and negotiate for commitments not to bring potential enforcement actions. Early consultation with (and genuine responsiveness to) all interested parties who might actively oppose either for-profit involvement in general or deviation from a particular gift restriction could reduce the prospect that they might subsequently try to persuade the attorney general to bring an enforcement action.

did not constitute a breach of trust even though provisions of the charitable trust that supported the facility seemed on their face to proscribe such a move.⁵⁰²

The court stated that charitable trusts held by educational institutions should "be so managed under the particular trust provisions as to be of maximum usefulness, thus serving to the greatest possible extent the public as the ultimate beneficiary."⁵⁰³ Managers of an educational institution, the court said, have a duty to consider the institution's "overall welfare" and "ultimate purposes" when construing the provisions of a charitable trust.⁵⁰⁴ "Resolution of possibly divergent interests," the court added, "is inherent in the holding and management by a single institution of a number of public trusts for independent, related or overlapping purposes."⁵⁰⁵ The practical implication of this holding and reasoning is that institutions have broad discretion to construe donors' restrictions as consistent with the institutions' strategic decisions,⁵⁰⁶ including the decision to place teaching hospital operations in the hands of a for-profit firm.⁵⁰⁷

Even where there can be no doubt that a donor's restriction bars the sale or lease of a hospital, or the subsequent use of a gift, it appears that a nonprofit may, without prior judicial approval, lawfully proceed with the sale, lease, or subsequent use so long as a court would have permitted the

502. 213 N.E.2d 840 (Mass. 1966). The case involved a charitable trust given to Harvard in 1872 for the stated purpose of establishing and maintaining an arboretum, to be named the "Arnold Arboretum," on a designated off-campus site. Harvard complied with these instructions and eventually applied income from the trust to support a library and herbarium at the Arboretum. In 1953, however, the university relocated most of the library and herbarium to its Cambridge campus. Harvard's botany research program benefited greatly, but reputation of the Arnold Arboretum suffered. The Massachusetts Attorney General brought an information against Harvard alleging breach of trust. The attorney general contended that because the trust indenture of 1872 limited the gift's use to establishment and maintenance of the Arnold Arboretum, trust-supported facilities at the arboretum could not be moved to another site. But the court's strained construction of the indenture permitted Harvard to apply the trust so as to maximize its benefit to the university's botany program as a whole. *Id.*

503. *Id.* at 847.

504. *Id.* at 848.

505. *Id.*

506. Although the ruling on its face applies only to educational institutions, the need for "resolution of . . . divergent interests" in order to advance an institution's "overall welfare" is equally great for other institutions supported by multiple charitable gifts. Thus, even if a court were reluctant to characterize non-university owned teaching hospitals as educational institutions, the Massachusetts high court's holding and reasoning should still apply.

507. Nevertheless, an important caveat should be kept in mind: the virtual absence of analogous cases means that there is no guarantee that other jurisdictions would follow the Massachusetts high court's permissive approach to such situations. This uncertainty reflects the rarity of recent charitable enforcement litigation.

deviation. Decisions in several states support the proposition that a departure from a restriction on a charitable trust will not be set aside or annulled if a court would have approved it on proper application.⁵⁰⁸ Thus, deviation and cy pres relief can, in effect, be granted retroactively. If a nonprofit's managers are confident about their case for deviation or cy pres and willing to chance an enforcement proceeding, they may opt to act in violation of a restriction without first applying to a court.

VII. APPROACHES TO AGREEMENT

The prospect of investor-owned firms assuming responsibility for hospital operations at academic medical centers is something novel in the recent history of American medicine. Yet the mutual interest in such arrangements on the part of for-profit hospital chains and some academic centers is a logical outgrowth of developments years in the making in both the academic sector and the hospital industry as a whole. I have sought in this Article to explore these developments with an eye toward understanding the interests and objectives, both mutual and antagonistic, that have prompted teaching centers and for-profit firms to consider sale and lease arrangements. I have also examined the objections raised by critics of the for-profit operation of teaching hospitals, and I have surveyed some potential regulatory and legal obstacles to the execution of sale and lease agreements. My conclusion is that such arrangements (1) have considerable potential to result in mutual benefit for academic centers and for-profit firms, (2) are not objectionable in principle on public policy grounds, and (3) are, within certain limits and perhaps with some exceptions, not barred by established regulatory and legal constraints. New financial support for research and teaching, an influx of capital for academic and clinical needs, and sounder fiscal footing for hospital operations are among the possible advantages for academic centers. Viewed from the perspective of both academic medicine and the public interest, these arrangements offer potential benefits that outweigh their risks.

Nevertheless, there are substantial hazards for both academic centers and their prospective for-profit partners. For the latter, the risk is exclusively financial: arrangements of the kind considered in this Article require the commitment of large amounts of capital, the assumption of responsibility for potential operating losses, the sharing of operating

508. CHARITIES, *supra* note 430, at 461 (citing cases from Arkansas, California, Illinois, Kentucky, and Ohio).

authority with academic administrators who are uncommitted to protecting the corporate bottom line, and toleration of the uncertainty of eventual payoff (whether from profitability of the teaching hospital itself, increased utilization of other hospitals as a result of the prestige of an academic affiliation, or the success of a vertically integrated system built around the teaching center). For academic medical centers, the greatest hazards may be noneconomic. By entrusting hospital operations to an investor-owned firm, an educational institution risks attenuation of its authority over clinical teaching and research. Moreover, it renders itself potentially vulnerable, financially and otherwise, to the changing business strategies and fortunes of a firm operating in a volatile industry.

To maximize the potential benefits and to secure adequate protection against the hazards, careful prenegotiation planning by nonprofit managers is essential. I will conclude this Article by briefly considering the major issues that merit attention in talks regarding sale and lease arrangements and the terms of subsequent affiliations between acquired or leased hospitals and academic institutions. Though I will address these issues from the perspective of the academic institutions (and other nonprofit sellers and lessors) involved, I will try to be sensitive to the interests of prospective for-profit partners. By remaining attentive to the concerns and priorities of their opponents, academic and other nonprofit negotiators can better discern ways to further mutual interests and can more effectively bargain for their own objectives (and the public interest)⁵⁰⁹ where interests conflict.

First, however, I will make some recommendations regarding the process by which an academic medical center might weigh the option of

509. The interests of academic medicine are hardly synonymous with the public interest, however one understands this latter, uncertain concept. The discussion, earlier in this Article, of academic physicians' keen responsiveness to economic incentives generated by a highly imperfect medical marketplace illustrates the potential for divergence between the interests of academic medicine and society as a whole. On the other hand, it may be reasonable to view academic medical leaders as rough surrogates for the public interest when academic institutions enter into cooperative arrangements with investor-owned hospital firms. To the extent that the academic medical community's skepticism about for-profit hospital care is driven by public-regarding concerns (as opposed to narrow self-interest), the notion that academic leaders function as surrogates for the public interest becomes more plausible. In deferring to academic leaders' concerns and to private contractual arrangements, I herein presume the rough validity of this notion.

Should my presumption be unwarranted, then deference to academic medical leaders' concerns (and to contractual arrangements between academic institutions and investor-owned chains) would amount to abandonment of public-regarding concerns. A comprehensive appraisal of the extent to which the academic medical community functions as an acceptable surrogate for the public interest with respect to health policy issues would be of immense value. Such a project is beyond the scope of this Article.

a hospital sale or lease before proceeding to serious negotiations with a for-profit firm.

A. THE DECISION TO PROCEED

A critical lesson from the abortive McLean Hospital/HCA sale negotiations, which foundered on the opposition of astonished faculty members after HCA's purchase offer became public knowledge,⁵¹⁰ is that process matters. Any gains in bargaining efficiency and flexibility that resulted from the secrecy that enshrouded the Massachusetts General Hospital trustees' consideration of a sale were lost as a result of the faculty resentment that ensued when the deal was publicly presented as a virtual *fait accompli*. Several MGH and McLean officials who played key roles in developing the plan and negotiating with HCA attributed the plan's collapse to the MGH trustees' failure to involve faculty from the early stages of its formulation.⁵¹¹ These officials suggested that faculty hostility reflected negative feelings about their exclusion from the process rather than dispassionate analysis of the plan's benefits and risks.⁵¹²

The McLean experience illustrates the danger of failing to involve an academic medical center's constituencies in the making of a decision so pivotal as the sale or lease of hospital operations to a for-profit firm. An academic medical community is hardly a strictly hierarchical social system. Influential subgroups that are disturbed by a portentous institutional change may be able to marshal the political strength⁵¹³ to resist it. The early involvement of major constituencies in the decision-making process could be decisive in winning their support. Moreover, such involvement may improve the quality of the decisions reached. Representatives of constituencies that are directly affected may be better situated than trustees and administrators to identify problems and advantages inherent in particular options, suggest revisions, and develop entirely new approaches. In addition, once a decision to enter serious

510. See *supra* text accompanying notes 1-9.

511. Interview with Francis Burr, Chairman of the MGH Board of Trustees (June 1986); Interview with Francis deMarneffe, M.D., General Director of McLean Hospital (Nov. 1985); Interviews with other officials, on condition of anonymity (Nov. 1985).

512. *Id.*; cf. Faculty Advisory Committee Report, *supra* note 6 (report by Harvard faculty panel to the Dean of Harvard Medical School, giving the HCA purchase proposal a generally favorable review on the merits but urging the Dean to take steps to block a deal because of entrenched faculty opposition).

513. Such strength may come either from within the academic center (e.g., the widespread negative feelings about for-profit hospitals among Harvard faculty) or outside (e.g., the Massachusetts Attorney General's reported willingness to take legal action to prevent the sale of McLean to HCA, see *supra* text accompanying notes 4-5).

negotiations with a for-profit firm has been reached, trustees and administrators armed with input from a participatory decision process are likely to go to the bargaining table with a better grasp of their constituencies' interests and priorities.

A useful model is the process by which the administration and board of trustees of George Washington University elected to begin negotiations with AMI about a possible purchase or leasing deal. In 1983, the board authorized a study, to be conducted jointly with AMI, into the option of selling or leasing the university's hospital to a for-profit firm in order to insure the long-term availability of sufficient capital to maintain the hospital at a state-of-the-art level.⁵¹⁴ The administration then formed a steering committee and four specialized "working groups" to carry out the study.⁵¹⁵ Representatives of multiple constituencies (including full-time and voluntary faculty, interns and residents, medical students, and nursing staff) participated, as did several AMI officials.⁵¹⁶

As the study proceeded, the problems of capital formation and maintenance of fiscal stability received heightened attention within the medical center's constituencies. The shortcomings of alternative solutions—for example, philanthropy, debt financing, and university-sponsored for-profit ventures—became more widely known.⁵¹⁷ In late 1984, after nearly a year of discussions, the steering committee and working groups submitted a report recommending that the university begin formal sale or lease negotiations with a for-profit hospital chain. The report set forth some minimum requirements for an agreement and identified other issues for negotiation.⁵¹⁸ In 1985 the university invited formal purchase and leasing proposals from for-profit chains. Although some at George Washington expressed misgivings about the prospect of such an arrangement, there was nothing comparable to the active opposition that greeted public disclosure of HCA's bid to purchase McLean.⁵¹⁹

514. Report of the joint George Washington University and American Medical Int'l study into the feasibility of a relationship between the George Washington University Medical Center (GWUMC) and an investor-owned health care delivery system (Nov. 20, 1984) (on file at the GWUMC Office of the Dean for Administrative Affairs) [hereinafter GW Report].

515. *Id.* (The working groups focused on education and research, clinical affairs, hospital operations, and fiscal implications.).

516. *Id.*

517. Interview with Philip Birnbaum, George Washington University Medical Center Dean for Administrative Affairs, in Washington, D.C. (Nov. 1985) [hereinafter Birnbaum Interview].

518. GW Report, *supra* note 514.

519. Birnbaum Interview, *supra* note 517. Another example of a decision process that was opened to the relevant constituencies, albeit in a less formal manner than at George Washington, is that which preceded AMI's 1984 acquisition of the St. Joseph Hospital in Omaha, Nebraska, the main teaching hospital of the Creighton University School of Medicine. An initial expression of

Ideally, the involvement of representatives of a medical center's constituencies should begin with a communal effort to specify the problems and objectives that have led to consideration of a deal with a for-profit firm. The process should then proceed to the development and evaluation of alternative approaches to these problems and objectives. It might be helpful at this stage to separate the creative work of inventing alternatives from the critical processes of assessing and deciding among them.⁵²⁰ To foster a sense of shared purpose and to improve the analytic quality of discussions, a simple rule might be invoked during the critical phase: Criticism of an alternative should be accompanied by either a suggested revision to reduce the identified problem or an argument about how another alternative lessens the problem. Should this process result in a decision to enter serious negotiations with a for-profit firm, the process participants' perception of this decision as a collective achievement could strengthen community support.

B. ISSUES FOR NEGOTIATION

The major issues that merit attention before and during sale or lease negotiations fall into four closely linked categories—financial questions, the delineation of spheres of authority, the development of new program opportunities, and the design of safeguards for all parties (including dispute resolution mechanisms and provisions for termination of an agreement). In briefly addressing these issues, I will propose some bottom line conditions that prospective sellers or lessors ought to insist upon to protect essential interests. I will also make some suggestions about how prospective sellers or lessors might maximize the benefits and protections afforded by an agreement, taking into account the interests of for-profit negotiators.⁵²¹

interest by AMI in late 1983 led to informal talks between AMI and officials of Creighton and the independent nonprofit corporation that owned St. Joseph. AMI then submitted a purchase proposal, and at this point it was widely communicated that negotiations were underway. The subject was discussed in faculty and medical staff meetings, gatherings of the university's council of deans, and other university fora. Moreover, since St. Joseph had been operated as a Catholic hospital, the Archbishop of Omaha was consulted and the matter was addressed by the Archdiocesan Priests' Senate. These discussions engendered broad support for a sale, provided that certain conditions were met, and they supplied some guidance in formal negotiations. Richard L. O'Brien, *The Decision-making Process*, in *THE INVESTOR-RELATED ACADEMIC HEALTH CENTER AND MEDICAL EDUCATION: AN UNCERTAIN COURTSHIP* 192, 194-95 (1986).

520. See ROGER FISHER & WILLIAM URY, *GETTING TO YES: NEGOTIATING AGREEMENT WITHOUT GIVING IN* 62-64 (1981) (urging negotiators to "separate inventing from deciding" so as not to inhibit creativity in prenegotiation planning).

521. At least two agreements, as a rule, are likely to be involved—the sale or lease contract itself and the accompanying affiliation agreement between the hospital and the associated medical school.

1. *Financial Questions*

The financial arrangements between the parties should be negotiated as a package, with an emphasis on optimizing the benefits accruing to the seller or lessor (and to the affiliated medical school) from a given aggregate expenditure by the for-profit firm. Major items include the sale price or leasing fee, corporate support for capital improvements and academic programs, funding for indigent care, and allocation of shared operating expenses between hospital and medical school. Distributional conflicts between separate nonprofit beneficiaries of an agreement—for example, a medical school and an independent nonprofit hospital owner with plans to create a foundation from sale proceeds⁵²²—should be dealt with in parallel talks while bargaining between the for-profit and the hospital's owner is underway. Moreover, the parties to an agreement should make the necessary institutional arrangements to ensure continued access to federal grants and private, tax-deductible, and tax-exempt contributions.⁵²³

The sale price or leasing fee should reflect not only the hospital's potential to generate income, but also the buyer's or lessee's improved access to tertiary care expertise and the economic goodwill value of an academic affiliation. The substantive value of an academic center's expertise and the goodwill value of academic prestige should be appraised in terms of both their projected impact on the competitiveness of other hospitals operated by the buyer or lessee and their potential utility in the development of a vertically integrated health care system.

Negotiators for the seller or lessor (and the affiliated medical school if the seller or lessor is a separate entity) should seek a commitment from the buyer or lessee to make desired capital improvements to the hospital. The capital needs that occasioned consideration of for-profit involvement

In some cases—for example where government agencies contract with a teaching hospital for the provision of indigent care, *e.g.*, *infra* text accompanying notes 530—additional agreements with other parties may be necessary. The following discussion addresses issues that may arise in negotiations on any of these agreements.

522. *See supra* text accompanying note 19.

523. This will require the transfer of all corporate responsibility for the administration of academic programs supported by federal or philanthropic grants from the hospital to the medical school or to another nonprofit entity. Tax experts should be consulted about the administrative arrangements necessary to insure eligibility for deductible and exempt contributions. A model arrangement was developed in talks on HCA's unsuccessful attempt to purchase McLean Hospital from the Massachusetts General Hospital. This plan called for Harvard Medical School to act as the grantee for all research conducted at McLean, to become responsible for negotiating indirect cost rates, and to negotiate with McLean for space and support services. Faculty Advisory Committee Report, *supra* note 6, app. B.

should be stipulated in the sale or lease agreement, along with the for-profit firm's plan to meet them.⁵²⁴ The agreement should also specify, in dollar or programmatic terms, the for-profit's commitment to support research and education. Potential approaches include the creation of permanent endowments to support faculty salaries⁵²⁵ and other research and teaching activities,⁵²⁶ annual subsidies for research and teaching⁵²⁷ (including faculty and house staff salaries⁵²⁸), and gifts for new academic facilities. In addition, the for-profit operator's indigent care obligation

524. An example is the agreement governing AMI's acquisition of the St. Joseph Hospital, the Creighton University School of Medicine's primary teaching hospital, from an independent, non-profit firm. AMI agreed to spend at least \$10 million, beyond that required for routine plant maintenance and replacement, for the purchase of new land and equipment and the development of parking facilities. In addition, the corporation committed itself to construction of a new psychiatric facility after obtaining the necessary regulatory approvals. O'Brien, *supra* note 519, at 198. In the negotiations leading up to HCA's formal offer to purchase McLean Hospital, HCA agreed to pay an estimated \$35 million for a renovation and expansion program covered by a recently received Certificate of Need. Faculty Advisory Committee Report, *supra* note 6, app. B.

525. An example is HCA's commitment, in its McLean Hospital purchase offer, to endow five Harvard Medical School faculty positions. HCA would have contributed \$6.25 million for this purpose (\$1.25 million per professorship). Faculty Advisory Committee Report, *supra* note 6, app. B.

526. In acquiring the St. Joseph Hospital, AMI agreed to contribute \$3 million to the "Health Future Foundation," an entity created by the seller (out of sale proceeds) for the support of academic programs in the health sciences at Creighton University. O'Brien, *supra* note 519, at 198. During its joint "study" with George Washington University into the possibility of acquiring or leasing the university's hospital, AMI indicated its willingness to establish endowments for education and research. AMI Letter, *supra* note 210, app. III at 24.

As part of its agreement with the University of Louisville School of Medicine regarding the long-term lease of the school's principal teaching hospital, Humana contributed \$4.5 million to the university, to be held in escrow for five years (with interest accruing to the medical school for the support of research and teaching programs) before reverting entirely to the medical school for its unrestricted use. Rollo, *supra* note 205, at 124-25.

527. In its proposal to purchase McLean Hospital, HCA offered to guarantee continued cross-subsidization of educational programs from clinical revenues at a rate equal to the pre-acquisition rate (i.e., HCA indicated it would use the last pre-sale cross-subsidy as a base and increase this amount annually by a percentage equal to each year's rise in patient revenues). Faculty Advisory Committee Report, *supra* note 6, app. B. In its agreement with the University of Louisville School of Medicine regarding the long-term lease of the school's teaching hospital, Humana assigned twenty percent of the hospital's pre-tax profits to the school's dean for the support of research and educational programs. Rollo, *supra* note 205, at 124. When AMI acquired the St. Joseph Hospital, the firm pledged \$200,000 per year for ten years to Creighton University to support a Center for the Study of Health Policy and Ethics. O'Brien, *supra* note 519, at 198.

528. Humana's agreement with the University of Louisville School of Medicine, for example, included a commitment to pay the salaries of clinical service chiefs and 174 of the university's approximately 400 interns and residents. Rollo, *supra* note 205, at 125-26. In a report on its joint "study," with AMI, of the option of selling or leasing its hospital to a for-profit firm, a George Washington University panel indicated that any affiliation agreement with a for-profit would have to specify the support to be provided for faculty salaries. GW Report, *supra* note 514. AMI indicated, in general terms, a willingness to provide some support for faculty participating in patient care, research, and teaching at the hospital. AMI Letter, *supra* note 210, app. III at 24.

should be specified, either in the sale or lease agreement or in the affiliation accord between the hospital and the medical school.⁵²⁹

Sale or lease negotiations between a for-profit firm and nonprofit parties may in some cases present opportunities for creative, mutually advantageous solutions to the problem of the medically indigent. An outstanding example is the indigent care reimbursement fund established by Humana and state, county, and city officials in conjunction with Humana's long-term lease of the University of Louisville's principal teaching hospital. The state, county, and city governments made contributions to the fund based on estimates of the region's indigent care needs. Humana agreed to cover any indigent care expenses in excess of these contributions.⁵³⁰ In the absence of a comprehensive national health insurance program, the parties to a sale or lease agreement might also consider working with other private hospitals to develop regional and state-wide cost-spreading approaches to the financing of care for the medically indigent.⁵³¹

In negotiating economic issues, nonprofit representatives ought to be mindful that different elements in a package arrangement may present different problems and advantages to a for-profit firm. Tax considerations may make it advantageous for a firm to commit resources in a particular manner—for example, to capital improvements—and more costly to apply equivalent resources in another way. Similar dollar amounts

529. For example, when AMI acquired St. Joseph Hospital (the biggest provider of unpaid care in Omaha, Nebraska), the corporation agreed to continue the indigent care policies jointly established by Creighton University and the hospital's previous, nonprofit management. O'Brien, *supra* note 519, at 197. HCA's offer to purchase McLean Hospital included a commitment to continue uncompensated care at the same low rate—only 2.6 percent of gross revenues—supported by McLean under nonprofit management. The Harvard faculty panel that urged rejection of HCA's purchase offer indicated it would have recommended an increase in this percentage had it endorsed a sale to HCA. Faculty Advisory Committee Report, *supra* note 6.

530. Rollo, *supra* note 205, at 123. The state county and city contributions totaled nineteen million dollars during the first year of the agreement. The government contributions increase annually according to an inflationary factor. Kmetz, *supra* note 227, at 176. During the first sixteen months of the agreement, indigent care billing exceeded government contributions by \$6.6 million. This difference was absorbed by Humana. Rollo, *supra* note 205, at 124. After the agreement's first five years, university officials gave it glowing reviews. Indigent persons, they concluded, were receiving higher quality care than at city hospitals, with "fewer inefficiencies related to bureaucratized and politicized health care." Joel Kupersmith, Joseph C. Allegra & Donald R. Kmetz, *For-Profit Management of a University Hospital*, 318 NEW ENG. J. MED. 1402 (1988).

531. See Alexander Williams, *Bearing the Burden of Indigent Care*, in THE INVESTOR-RELATED ACADEMIC HEALTH CENTER AND MEDICAL EDUCATION: AN UNCERTAIN COURSHIP 76, 82 (1986) (urging development of state-wide, cost-spreading approaches including insurer-financed "all-payer" systems and hospital-funded charity care pools).

committed in various ways may have very different effects on the appearance of corporate balance sheets—an important consideration for any publicly-held firm. Additionally, the benefits a firm derives from a contribution may be greater if the contribution is presented as a charitable gift rather than as compensation for something provided to the firm. By sensitizing themselves to such considerations and tailoring strategies accordingly, nonprofit negotiators will better serve their own constituencies' interests.

2. *Authority*

The misgivings of many academic physicians about involvement with for-profit hospital chains reflect, in large measure, fears about loss of authority over an array of academic, clinical, and other matters.⁵³² In the coming years, some diminution of physician autonomy may be inevitable—not as a consequence of the for-profit form specifically, but rather a result of the high capital intensity, mounting bureaucratic complexity, and growing pressure for cost control that now characterize the health services industry. Yet a well-drafted agreement between a for-profit buyer or lessor and a medical school can assure academic administrators and faculty of as much authority over academic programs and clinical matters as they might have if they were dealing with a nonprofit hospital.

In negotiating the terms of a sale or lease and a subsequent affiliation, medical school representatives ought to insist on a number of minimum requirements. The most important of these pertain to the authority and composition of the hospital's governing board. To ensure that ultimate legal responsibility for the hospital's operations remains vested in its board and does not shift to the for-profit chain's board of directors, the hospital ought to be incorporated separately from its for-profit parent.⁵³³ Under such an arrangement, the hospital board's power will still

532. See, e.g., GW Report, *supra* note 514 (During George Washington University's study of possible for-profit involvement, "undifferentiated anxiety" about the investor-owned chains was "refined" into concern about who would have control over a wide range of academic and clinical matters.).

533. If individual facilities in a multihospital system (whether for-profit or nonprofit) are not separately incorporated, legal responsibility for the operations of each facility rests with the system's board of directors. Harty & Mulholland, *supra* note 380, at 23. The significance of this responsibility has been heightened in recent years by court decisions holding hospital boards accountable for lapses in the quality of care. See *supra* note 383.

For-profit chains have indicated a willingness to operate teaching hospitals as separate corporations. In its proposal to purchase McLean Hospital, for example, HCA said it would create a wholly owned subsidiary corporation (with a separate board) to assume McLean's assets and liabilities. Faculty Advisory Committee Report, *supra* note 6, app. B.

be circumscribed to some degree by the parent corporation's ultimate authority over the hospital's budget, but the hospital board's legal responsibility for operational matters should enhance its ability to act effectively in a supervisory role.

This role should be made plain by provisions in the sale, lease, or affiliation agreement specifying the board's authority. The specifications accepted by HCA in its proposal to purchase McLean Hospital are a useful model. HCA indicated it would give McLean's governing board "full authority" over all operational matters except "final approval" of the patient care budget.⁵³⁴ This authority was to include "general authority" to "oversee" patient care, teaching, and research.⁵³⁵ Proposed capital improvements (other than those specified in the purchase agreement) would have required approval by both the board and HCA's management. In addition, the appointment of the hospital's director and all M.D. and Ph.D. staff was to be subject to the board's approval.⁵³⁶

To ensure that the governing board remains an effective mechanism for the maintenance of academic authority over teaching, research, and clinical care, medical school officials ought to have power to appoint a majority of the board's membership.⁵³⁷ Representatives of the for-profit owner or lessor should also sit on the board in order to communicate management's concerns and convey academic and community concerns back to corporate headquarters and the firm's on-site managers. Otherwise, the board's composition should depend on the individual circumstances of each case. Some community representation may be

534. *Id.* at app. A.

535. *Id.* at app. B. Administration of the "teaching and educational budget" was to be "under the jurisdiction" of the board, with the budget's size to be specified in the purchase agreement itself. *Id.*

536. *Id.*

537. During the joint George Washington University-AMI "study" of possible AMI operation of the university's hospital, the university proposed, and AMI agreed, that the hospital's governing board would be composed of four senior medical school officials and three representatives of AMI. George Washington's senior health sciences official (the vice president for medical affairs) was to be the chairman. GW Report, *supra* note 514, exhibit 10; AMI Letter, *supra* note 210, app. I. In its proposal to purchase McLean Hospital, HCA agreed to a governing board, or "committee," consisting of the hospital director (appointed by HCA with the board's approval), three members named by the dean of the Harvard Medical School, three appointed by the chairman of the Harvard-affiliated Massachusetts General Hospital, and two named by the chairman of HCA. Thus the medical school and an allied institution (MGH) were to have had at least a six to three majority. Faculty Advisory Committee Report, *supra* note 6, app. B.

appropriate, particularly for teaching hospitals with substantial commitments to indigent care or other charitable service.⁵³⁸

Besides specifying the authority and composition of the governing board, an agreement ought to stipulate that academic personnel matters—including appointments (except for final approval by the hospital's governing board), tenure decisions, faculty compensation policies, and rules governing outside activities—remain under medical school control.⁵³⁹ Such a provision would further insulate research and education from the economic pressures that the governing board, including its academic members, will inevitably experience as it exercises its supervisory responsibilities.⁵⁴⁰ In order to provide additional insulation from business pressures, corporate responsibility for the administration of all research programs (whether supported by outside grants or by contributions from the for-profit chain) should be transferred from the hospital to the medical school or a separate nonprofit entity.⁵⁴¹

An agreement should also make plain that neither hospital management nor corporate headquarters may restrict publication or other dissemination of results from research conducted at the hospital or funded by the owner or lessor.⁵⁴² Moreover, an agreement ought to proscribe the use of research results in corporate advertising and publicity material without permission from participating faculty members in order to shield peer review of clinical innovations from interference by corporate promotional activity. Similarly, corporate financial support for research programs should not be contingent on faculty consent to the use of research results for promotional purposes. Medical school and corporate officials may also wish to negotiate provisions for determining patent rights and

538. The governing board of the Creighton University-affiliated St. Joseph Hospital, acquired by AMI in 1984, includes members from the community and the Omaha-based Boys Town National Institute, an affiliate of St. Joseph. O'Brien, *supra* note 519, at 199.

539. Cf. Faculty Advisory Committee Report, *supra* note 6, app. B (HCA's proposal for purchase of McLean Hospital stipulated that academic personnel policies would remain as they were before the sale).

540. *But cf.* GW Report, *supra* note 514 (plan developed in joint George Washington-AMI study of possible for-profit ownership or lease of the university's hospital placed ultimate authority over academic personnel policies in the hands of the hospital governing board controlled by medical school administration).

541. Such a transfer would also be necessary to enable faculty to continue receiving federal and private grants for research conducted at the hospital. *See supra* note 523.

542. A danger inherent in any collaborative relationship between academia and the for-profit sector is that incentives to keep some knowledge proprietary could compromise the free exchange of scientific information and ideas. *See, e.g.,* A. Bartlett Giamatti, *Free Market and Free Inquiry: The University, Industry, and Cooperative Research*, in *PARTNERS IN THE RESEARCH ENTERPRISE 3* (Tomas W. Langfitt, Sheldon Hackney, Alfred P. Fishman, & Albert V. Glowasky eds., 1983).

allocating potential licensing income from applications of research funded by the corporation or conducted at the hospital.⁵⁴³

Other contractual protections for education and research might include the following: (1) an express statement that all patients admitted to the hospital or seen in outpatient clinics are available, at faculty discretion, to students and house staff for teaching purposes;⁵⁴⁴ (2) a provision barring hospital management from anything more than an advisory role in the design and administration of teaching programs; (3) a guarantee of faculty authority to specify procedures and to make decisions regarding the kinds of patients to be admitted⁵⁴⁵ (in order to ensure clinical diversity for teaching purposes and faculty access to clinical groupings needed for research protocols); and (4) a statement of faculty authority to decide what clinical services will be provided⁵⁴⁶ and how many residents will be trained in each specialty program. These provisions, however, are not vital so long as the hospital governing board has clear authority over these matters and is controlled by a medical-school-appointed majority.

An essential link in the logic justifying the existence of for-profit hospitals is the physician's independence as a clinical "purchasing agent."⁵⁴⁷ Protection for this independence should be an indispensable part of any affiliation arrangement between a medical school and a for-profit teaching hospital. To shield physician judgment from hospital management's economic leverage, an agreement should state clearly that no physician with any patient care responsibilities may be employed or otherwise compensated individually by the hospital.⁵⁴⁸ This principle

543. See generally OFFICE OF THE GENERAL COUNSEL, NAT'L SCIENCE FOUND., REPORT ON A NATIONAL SCIENCE FOUNDATION WORKSHOP ON INTELLECTUAL PROPERTY RIGHTS IN INDUSTRY-UNIVERSITY RESEARCH RELATIONSHIPS: SELECTED STUDIES (1982) (discussing the allocation of patent rights and income from commercial applications of research).

544. The medical school/hospital affiliation agreement accompanying Humana's long-term lease of the University of Louisville's principal teaching hospital specifies that all inpatients are available for teaching. Kmetz, *supra* note 227, at 175.

545. See GW Report, *supra* note 514, exhibit 7 (indicating that George Washington University would require such a provision as a prerequisite for sale or lease of its hospital to a for-profit).

546. See *id.*

547. See *supra* text accompanying notes 290-97, 356-60.

548. See, e.g., Faculty Advisory Committee Report, *supra* note 6, app. B (HCA's purchase offer for McLean Hospital included the proviso that no McLean staff physician would be "employed directly" by HCA).

could be implemented through creation of a separate, nonprofit corporation to negotiate and administer compensation for faculty-provided inpatient and outpatient physician services at the hospital.⁵⁴⁹ Alternatively, the medical school itself could negotiate physicians' fees with the hospital and administer compensation for clinical services. Physicians not participating in a collective faculty compensation plan—for example, *gratis* faculty and other community practitioners—could continue to receive fee-for-service reimbursement from patients or third party payers.⁵⁵⁰

Additional protection for the independence of physicians' clinical judgment should be secured by contractual language that preserves the self-governing authority of the hospital's medical staff with respect to membership and clinical privileges (e.g., admitting and operating privileges).⁵⁵¹ A requirement that staff privileges be conditioned on a faculty appointment⁵⁵² would provide further protection, in the form of a countervailing institutional alliance, against the risk of management interference in physicians' clinical judgment. It may, moreover, be attractive to the for-profit buyer or lessor as a visible indicator of high quality clinical care. However, at teaching hospitals with substantial numbers of nonfaculty, community practitioners on staff, insistence on such a contractual requirement may not be worth the cost in divisiveness.

Finally, a nonprofit party to a sale, lease, or affiliation agreement may want contractual assurance that new management will continue the hospital's commitment to a particular mission. The seller or lessor of a hospital with a religious mission could negotiate for a provision that mandates adherence to a denomination's principles of medical ethics⁵⁵³

549. The terms of HCA's offer to purchase McLean Hospital included creation of an independent faculty practice plan, established as a nonprofit corporation chaired by McLean's Harvard-designated psychiatrist-in-chief, to administer physician compensation for all hospital-based patient care. A faculty appointment would have remained a requirement for privileges at McLean. Professional fees were to have been set in negotiations between the practice plan and hospital management. HCA was to make payments to the practice plan at an amount based on pre-acquisition staff salaries and adjusted annually for inflation and changes in total patient care hours. *Id.*

550. Likewise, physicians employed by independent HMOs or other prepaid plans could continue to draw salaries from their employers for taking care of patients admitted to a for-profit teaching hospital.

551. See GW Report, *supra* note 514 (stating that a commitment by a for-profit firm to preserve Hospital Medical Staff Organization's structure, function, by-laws, rules, and regulations was a prerequisite for the sale or lease of George Washington University's hospital).

552. See Faculty Advisory Committee Report, *supra* note 6, app. B (HCA plan for acquisition of McLean Hospital included the requirement that all physicians granted privileges at McLean hold Harvard faculty appointment.).

553. See, E.g., O'Brien, *supra* note 519, at 196-97 (In acquiring the St. Joseph Hospital, which was founded by a Roman Catholic order and operated as a Catholic facility by subsequent owners, AMI committed itself by contract to administering St. Joseph in accordance with Catholic medical

and perhaps even designates some religious authority as the arbiter of compliance. Similarly, a party wishing to see a teaching hospital maintain a commitment to research and treatment for a particular disorder could press for contractual language explicitly stating and defining that commitment.

3. *New Program Opportunities*

The new program opportunities open to an academic medical center operating in partnership with a for-profit hospital chain should be another focus of negotiations. For teaching centers, these opportunities have considerable financial and academic allure. They also pose substantial risks. To maximize potential benefits and guard against the hazards, academic negotiators should seek commitments to desired programs and insist on effective medical school control over new ventures involving teaching center personnel and resources.

The financial attractions are several. New income streams for academic departments could flow from the marketing of educational programs to other hospitals operated by the for-profit buyer or lessor and to practicing physicians affiliated with these hospitals.⁵⁵⁴ The development by the for-profit chain of a regional, vertically integrated medical care system with the academic center as its hub⁵⁵⁵ may hold even greater income-producing potential for academic departments. Corporate commitment to developing the center as its tertiary care "flagship" could bring a new influx of capital for the acquisition of advanced technology, greatly enhancing academic clinicians' income-producing potential. New opportunities could include consultation requests from community practitioners affiliated with the chain's other facilities,⁵⁵⁶ additional inpatient tertiary care referrals, and the chance to staff chain-operated ambulatory surgery centers and other satellite facilities. Alluring academic prospects include a more diverse array of training sites, additional state-of-the-art technology for clinical research, access by investigators to the chain's systemwide clinical data base, and vastly increased numbers of patients for research protocols.⁵⁵⁷

ethics). Such a provision could specify particular procedures—e.g., abortion and *in vitro* fertilization—not to be performed in the hospital because they are proscribed by religious doctrine.

554. See *supra* text accompanying note 155.

555. See *supra* text accompanying notes 193-201 (discussing Humana's plans to develop regional, vertically-integrated medical service systems).

556. See *supra* text accompanying note 154.

557. See *supra* text accompanying notes 155-58.

The principal hazard, on the other hand, is that the unrestrained pursuit of revenue opportunities could eclipse academic priorities. In the face of uncontrolled incentives to act as entrepreneurs, faculty commitment to research and teaching could suffer severely.⁵⁵⁸ Another danger is that new clinical ventures initiated by the for-profit firm, perhaps even with the aid of some faculty, could draw patients away from preexisting programs operated by the medical school or its faculty practice plan.⁵⁵⁹ This could result in a loss of teaching and research opportunities as well as revenue.

Moreover, sale or lease of a teaching hospital to a for-profit chain will not in itself assure the resulting investor-related academic medical center of access to the new financial and academic opportunities alluded to above. Humana's long-term lease arrangement with the University of Louisville is a case in point. The signing of an agreement in 1983 had occasioned hopes for a networking of Humana facilities in the Louisville area, with the university hospital as Humana's regional tertiary care "flagship." However, to the chagrin of university officials, Humana proceeded to establish major tertiary care programs at its other area hospitals.⁵⁶⁰ Instead of emerging as the central element in a vertically integrated system, the university hospital became just another entry in a "fierce . . . internal corporate competition" between Humana's facilities.⁵⁶¹ The university's medical school consequently lost out on much of the new programmatic potential of a partnership with the for-profit sector.

To secure access to this potential and to guard against the hazards, a medical school should seek contractual provisions guaranteeing its teaching hospital a regional flagship role⁵⁶² and permitting centralized academic control over new ventures. An attractive model was developed by AMI and George Washington University during their joint study of teaching hospital sale and lease options.⁵⁶³ AMI offered to commit itself to developing a vertically integrated health services network in the Washington, D.C. area, with the George Washington University Hospital as

558. O'Leary, *supra* note 154, at 96, 102; cf. Cluff, *supra* note 67, at 2932 (The growing obligation of full-time clinical faculty to generate income from professional fees is eroding faculty commitment to research and teaching at non-profit hospitals.).

559. GW Report, *supra* note 514.

560. Kmetz, *supra* note 227, at 178-79 (citing, as examples, nuclear magnetic resonance imaging technology and Humana's artificial heart program).

561. *Id.* at 179.

562. *Id.*

563. GW Report, *supra* note 514.

its tertiary care hub.⁵⁶⁴ The corporation said it would delegate authority over the entire system to the university hospital's governing board, to be composed of four medical school officials and three AMI representatives.⁵⁶⁵ This would have enabled academic leaders to secure for their institution the "flagship" role that eluded the University of Louisville and to exercise effective veto power over new ventures believed to endanger academic priorities or existing income sources. In addition, AMI made a number of more specific promises relating to the faculty's and the university hospital's role in a vertically integrated network and to faculty and trainee access to new program opportunities.⁵⁶⁶ The university expressed great interest in AMI's proposals. But medical school officials indicated they would insist on a detailed contractual definition of the hospital's role in an integrated system and on limits upon the establishment of services potentially competitive with the faculty practice plan.⁵⁶⁷

Prospective buyers and lessees may not be so willing in all cases to make an academic medical center the nucleus of a regional, vertically integrated network and to delegate authority over the entire system to a medical-school-controlled governing body. But where the interested nonprofit parties believe that a sale or lease is in a teaching center's best interest for other reasons, their negotiators need not insist on full-fledged flagship status. They should, however, make sure that any commitments by the for-profit firm to particular relationships or ventures involving the teaching center are contractually defined in precise terms. Moreover, to protect academic priorities (and existing income sources) they should insist on veto power for medical school officials over new initiatives involving the hospital, the medical school, or individual faculty members.

4. *Conflict Resolution and Safeguards*

A sale or lease contract and any related affiliation agreements should also contain mechanisms for resolving differences between parties

564. See *supra* text accompanying notes 211-13.

565. See *supra* note 214 and accompanying text; *supra* note 529.

566. The corporation promised, *inter alia*, to make its area hospitals and other facilities available for teaching, AMI Letter, *supra* note 210, app. III at 11; to promote inpatient and outpatient tertiary care referrals to the university hospital and its faculty from other AMI facilities and their medical staffs, *id.* at 10, 22; to give the university's faculty practice plan the right of first refusal to staff AMI ambulatory care centers, *id.* at 22; and to involve faculty in corporation-sponsored continuing education programs for physicians at AMI hospitals throughout the mid-Atlantic region, *id.*

567. GW Report, *supra* note 514, at 10.

and coping with future developments not otherwise anticipated by contract language.⁵⁶⁸ Conflicts could arise out of almost any operating matter. But more serious disputes are likely to involve alleged breaches of contract, other disagreements about contract interpretation, and corporate actions that are not contractually proscribed but are believed by medical school administrators to endanger academic interests. Future developments arousing concern might include acquisition of the for-profit owner or lessee by another corporation, deterioration of the owner's or lessee's financial condition, or regulatory events with an adverse impact upon the owner or lessee. While recognizing the inevitability of compromise and risk, the medical school and other nonprofit parties should make sure that contractual mechanisms of problem resolution suffice to safeguard their essential interests.

The hospital governing board can serve as an adequate forum for the resolution of most problems. If it is set up as I have urged herein, with an academic majority and governing authority specified by contract (but-tressed by legal responsibility for hospital operations),⁵⁶⁹ the board should be able to resolve, in a manner acceptable to academic leaders, all matters pertaining to hospital operations.⁵⁷⁰ Moreover, the presence of corporate representatives on the board⁵⁷¹ renders it useful as a forum for dialogue between academic officials and corporate management regarding problems beyond the scope of the board's authority.

For such problems, however, additional mechanisms are necessary to reduce the vulnerability of academic interests to corporate fiat. One promising measure, proposed by George Washington University and agreed to by AMI in their joint study of sale and lease options, is a contractual guarantee of direct access by senior medical school officials to

568. Provisions that facilitate mutual adjustment by contracting parties to unanticipated developments are vital to the success of long-term relational agreements. Contractual specification of reasonable resolutions for all possible contingencies is not possible because the human capacity to anticipate contingencies is limited. HERBERT A. SIMON, *MODELS OF MAN* 198 (1957) (terming this cognitive limitation "bounded rationality"). The more immense the range of future contingencies, the more costly it is (to the point of impossibility) to resolve them in advance. See Oliver E. Williamson et al., *Understanding the Employment Relation: The Analysis of Idiosyncratic Exchange*, 6 BELL J. ECON. 250 (1975) (discussing implications of the inevitability of incomplete advance specification of contingencies and their resolution in employment contracts). Governance mechanisms are a practical substitute for detailed specification of terms in such agreements. Victor P. Goldberg, *Relational Exchange: Economics and Complex Contracts*, 23 AM. BEHAV. SCI. 337 (1980).

569. See *supra* text accompanying notes 533-40.

570. The board's authority in fiscal matters will be limited, however, by the corporation's control over the size of the hospital's patient care budget. See *supra* text accompanying notes 534-35.

571. See *supra* text accompanying notes 537-38.

top executives of the corporation.⁵⁷² Such a provision would at least assure academic officials of the institutional capacity to make top corporate management aware of academic concerns. The corporation's interest in remaining on good terms with its academic affiliate in order to reap the relationship's full benefits should make this line of access a useful instrument for protecting academic interests.

For disputes involving the interpretation or application of contractual language and not resolvable either at the governing board level or through informal communication between senior medical school and corporate officials, a more structured process is desirable. A contractual provision that empowers each party to convene formal negotiations in the event of a conflict over an agreement's terms would prevent dispute resolution by unilateral fiat in disregard of vital academic concerns. Such a provision would have added force if accompanied by a clause requiring that matters not settled in negotiations be submitted to binding arbitration.⁵⁷³

The ultimate safeguard against an agreement gone sour is contractual provision for termination—that is, cancellation of the lease or repurchase of the hospital by the original seller or some other nonprofit entity. From the perspective of the medical school and other involved nonprofit parties, a termination clause allowing cancellation or repurchase for any reason (thereby ensuring maximum flexibility to respond to changing conditions) might at first glance seem desirable. But because even a lease agreement would require a considerable initial outlay of corporate resources,⁵⁷⁴ for-profit negotiators are likely to look with disfavor upon proposals for permissive termination provisions.⁵⁷⁵ Some contractual protection for the investor-owned firm's reliance interest⁵⁷⁶ may be necessary to coax it into making the capital investment and other commitments desired by the medical school and other parties. Such protection,

572. GW Report, *supra* note 514, at 9-10; AMI Letter, *supra* note 210, app. III at 9.

573. The procedure for selecting arbitrators should somehow ensure that those chosen be sensitive to the interests and values of medical academia. One option might be a two-step approach, entailing (1) nomination of a candidate (or panel) by the medical school administration or the hospital governing board, and (2) corporate approval or rejection of this selection.

574. See *supra* text accompanying notes 523-28 (discussing up-front commitment of corporate resources, under both leasing and acquisition arrangements, toward capital improvements and endowments for academic activities).

575. To the degree that a producing firm must invest in long-lived, illiquid capital goods at the outset of a contract, it has a reliance interest in a subsequent right to serve. Victor P. Goldberg, *Regulation and Administered Contracts*, 7 BELL J. ECON. 426, 432-36 (1976). It can therefore be expected to bargain for a restrictive termination clause.

576. *Id.*

in the form of restrictions on the right to terminate the arrangement, may therefore be in these parties' best interests.⁵⁷⁷

The initial corporate commitment would probably be smaller for a lease than for an acquisition. A less restrictive termination clause should therefore be easier to obtain for a lessor than a seller; indeed, from the perspective of the nonprofit parties, ease of exit from a relationship with a for-profit firm may be the single greatest practical difference between a lease and a sale. The University of Louisville's long-term leasing agreement with Humana permits either party to cancel without cause by giving three years' notice.⁵⁷⁸ This permissive provision preserves maximum flexibility for the university, albeit at the cost of chronic uncertainty about Humana's continuing commitment.⁵⁷⁹

In acquisition negotiations, on the other hand, for-profit chains have insisted on more restrictive termination provisions. During its joint study with AMI of hospital sale and lease options, George Washington University said it viewed a "no fault" termination clause as a prerequisite for entry into either kind of arrangement.⁵⁸⁰ But AMI proposed to make the availability of a repurchase option contingent on a decision *by AMI* "to sell or otherwise not operate [the hospital] in the future."⁵⁸¹ HCA's bid to acquire McLean Hospital contained a comparable buy-back option, exercisable only in the event that the firm's directors "determine[d] that [HCA was] either unable or unwilling to operate the hospital" as called for in the purchase agreement.⁵⁸² The acquisition agreements finalized thus far contain similarly restrictive repurchase clauses. For example, the contract governing AMI's 1984 acquisition of the Creighton University-affiliated St. Joseph Hospital provides for a repurchase option only if AMI (1) breaches the agreement, (2) is itself acquired by another corporation, or (3) subsequently decides to sell St. Joseph.⁵⁸³ Given the for-profits' demonstrated aversion to open-ended

577. Cf. *id.* at 433 (in long-term producer-consumer contracts, optimal protection for producers' reliance interest is that at which expected marginal benefits for consumers of increased contract durability are just offset by expected marginal costs of decreased flexibility). Goldberg gives examples of such protection in long-term commercial leases and producer-consumer contracts. High capital-to-output ratios and long-lived, immobile capital are characteristics that make such protection attractive to contracting parties. *Id.* at 433-34.

578. Kmetz, *supra* note 227, at 175.

579. *Id.* at 178 (Vulnerability to cancellation by Humana obliges university officials to engage unceasingly in contingency planning.).

580. GW Report, *supra* note 514, executive summary.

581. AMI Letter, *supra* note 210, app. II at 5.

582. Faculty Advisory Committee Report, *supra* note 6, app. B.

583. The repurchase option may be exercised by the original seller (an independent nonprofit entity), its designee, or Creighton University. In the event that AMI receives other bids for St.

buy-back provisions, nonprofit negotiators would do well to anticipate potential conflicts and other developments likely to make repurchase desirable and to bargain for explicit mention of each as a buy-back clause trigger.

To ensure that repurchase remains feasible, the nonprofit seller (or any other party designated in a buy-back clause) should secure adequate financing arrangements. Sufficient capital—for example, a portion of sale proceeds—should be set aside by the seller for potential use as a down payment.⁵⁸⁴ As a safeguard against the uncertainty of future borrowing conditions, favorable financing terms for a repurchase should be made part of the sale agreement.⁵⁸⁵ Finally, the sale contract should specify a valuation process for setting the repurchase price.⁵⁸⁶

VIII. CONCLUSION

The transfer of teaching hospital operations to for-profit firms by sale or lease is not a national panacea for the financial problems afflicting academic medical centers. Sale and lease arrangements pose significant risks, as well as legal and regulatory difficulties. Moreover, interest by investor-owned health services systems in acquiring or leasing major teaching hospitals is unlikely to encompass more than a few or several major teaching centers in each region of the country.

Nevertheless, sale and lease arrangements of the sort discussed herein deserve a place in the repertoire of strategies available to academic medical centers for coping with an austere economic environment. Mounting competitive pressures are eroding teaching centers' ability to support academic programs via cross-subsidization from clinical revenue. A major increase in government support is unlikely in the near term, and

Joseph, the original seller, its designee, and Creighton have the right of first refusal. O'Brien, *supra* note 519, at 199, 206.

584. GW Report, *supra* note 514, executive summary. At least some of the income from this capital reserve could continue to be applied toward academic or other activities, so long as inflation remained within reasonable limits.

585. *Id.* The buy-back clause in the agreement governing AMI's purchase of the St. Joseph Hospital guarantees that AMI will offer financing for eighty percent of the repurchase price at the then-current prime interest rate. O'Brien, *supra* note 519, at 199.

586. GW Report, *supra* note 514, executive summary. The agreement governing AMI's purchase of the St. Joseph Hospital sets the buy-back price equal to the hospital's value as determined by depreciation on AMI's federal tax returns, unless another entity submits a purchase offer. In this event, the sum offered would become the price, with the organizations designated in the buy-back clause having the right of first refusal. O'Brien, *supra* note 519, at 206. Similarly, the repurchase option contained in HCA's unsuccessful offer for McLean Hospital set the facility's depreciated book value as the buy-back price. Faculty Advisory Committee Report, *supra* note 6, app. B.

the sheer size of academic medical enterprise now outstrips the capacity of private philanthropy to play more than a tiny role. Moreover, the debt capacity of nonprofit teaching centers is not sufficient to meet their massive capital needs. Academic leaders must become creative in adapting to this difficult environment. If prudently designed to secure the benefits and protect against the risks, hospital sale and lease agreements with the major for-profit chains have a legitimate role in the creative effort.

To those who insist on a vision of medicine in general, and academic medicine in particular, as separable from the exigencies of economic choice, such arrangements seem inherently distasteful. The very presence of the for-profit form in the health services field demonstrates that economic preferences and opportunities influence institutional behavior. But a keen responsiveness to economic opportunities has played an integral, albeit often unacknowledged role in the phenomenal growth of academic medical institutions over the last four decades. Tension between entrepreneurial incentives and the ideal of "pure" scientific inquiry uncontaminated by economic influences is hardly a new development. Ironically, in making entrepreneurship more visible, contractual arrangements between academic centers and the for-profit health services sector could provide increased protection for academic priorities by facilitating closer management of industry responses to economic incentives.